TESIS DOCTORAL

PAPEL DE LAS ESTRATEGIAS DE AFRONTAMIENTO Y DE LAS ATRIBUCIONES DE CULPA EN EL AJUSTE PSICOLÓGICO DE LAS VÍCTIMAS DE ABUSO SEXUAL INFANTIL

THE ROLE OF COPING STRATEGIES AND ATTRIBUTIONS OF BLAME ON THE PSYCHOLOGICAL ADJUSTMENT OF VICTIMS OF CHILD SEXUAL ABUSE

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Dr. Fernando Justicia Justicia y Dr. José Cantón Duarte, Directores de la Tesis “Papel de las estrategias de afrontamiento y de las atribuciones de culpa en el ajuste psicológico de las víctimas de abuso sexual infantil” de la que es autor D. David Cantón Cortés.

AUTORIZAN la presentación y defensa pública de la referida Tesis, emitiendo el siguiente informe:

La Tesis Doctoral reúne los requisitos científicos necesarios. Aborda una temática de gran relevancia social, cuyos resultados pueden ser importantes tanto a nivel preventivo como de intervención clínica con las víctimas de abuso sexual infantil. El doctorando lleva a cabo una exhaustiva revisión de la bibliografía existente al respecto, sobre la que fundamenta los objetivos generales y las hipótesis de trabajo. Por último, el análisis de los datos es pertinente y le permite obtener unos resultados y conclusiones que consideramos que serán de un gran valor para los conocimientos científicos en este campo social tan necesitado de ellos.

Y para que conste, expiden el siguiente certificado en Granada a 18 de Enero de 2010.

Fdo. Dr. Fernando Justicia Justicia Fdo. Dr. José Cantón Duarte

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ÍNDICE DE CONTENIDOS

OVERVIEW

Child Sexual Abuse (CSA) has been defined as “contacts and sexual interactions between a minor and an adult or between minors if there is a 5-year age difference between them or if the child/adolescent perpetrator is in a situation of power or control over the victim, even if there is no age difference” (Hartman & Burgess, 1989). In the last two decades, the sexual abuse of children has received a great deal of attention, both in the scientific community as well as the general population, due to the high prevalence rate and short- and long-term consequences (Cortés & Cantón, 2008; Del Campo & López, 2006). The prevalence rate, according to the only national study carried out in Spain (López, Carpintero, Hernández, Martín, & Fuertes, 1995), is 18% (15% of all males surveyed and 22% of all females surveyed experienced CSA).

Research has consistently suggested that CSA is associated with poor psychological outcome in the adult population, ranging from depression and self-esteem problems to sexual and personality disorders (e. g., Cantón & Justicia, 2008; Ferguson, Boden, & Horwood, 2008; Parks, Hequembourg, & Dearing, 2008). One of the most prevalent consequences of CSA is Post-traumatic Stress Disorder (PTSD). Several studies suggest that victims of sexual abuse have a high risk of experiencing PTSD symptoms during adulthood (e. g., Choi, Klein, Shin, & Lee, 2009; Kingston & Raghavan, 2009). However, there is great variability in both the severity of impairment and the symptoms experienced by CSA survivors (Merrill, Thomsen, Sinclair, Gold & Milner, 2001). It is therefore important to determine which variables may explain the adjustment differences in victims.

The variability in impact of CSA on the victim can be explained, at least in part, by the characteristics of the abuse. The relationship between a number of variables reflecting abuse severity and psychological adjustment of the victim have been studied. These studies however, have yielded inconsistent results (e. g., Paolucci, Genuis, &

Violato, 2001; Quas, Goodman, & Jones, 2003), suggesting that other factors may be more important than the characteristics of the abuse when predicting adjustment. Apart from this, although the variability in the abuse experience has a relationship with the differences observed in its effects, just a small percentage of these differences can be ascribed to the characteristics of the abusive act. In addition, as these characteristics are fixed and unchangeable their utility in a clinical treatment is limited. The study of the processes and mechanisms that can account for the development of a certain symptomatology would therefore be of great benefit for the purpose of designing an effective intervention (Banyard, Williams, & Siegel, 2001).

The work of the current Thesis focuses mainly on cognitive variables of the CSA victim associated with the development of PTSD symptomatology. Specifically, coping strategies employed and the attributions of blame about the abuse are considered. First, these variables are studied independently, analyzing their interactive effects with the characteristics of the abuse suffered. Second, a model designed to predict the PTSD symptomatology of the victim based on the characteristics of the abuse, the attributions of blame and the coping strategies employed by the victim is tested.

In spite of the majority of attention being focused on coping strategies and attributions of blame, there are other variables that can have an effect on the psychological adjustment of CSA victims. One of the most recognized models in the field of CSA is the Finkelhor & Browne´s (1985) traumagenic dynamics model. This model poses that the effects of CSA on psychological adjustment are due to four trauma-causing factors: powerlessness, betrayal, stigmatization and traumatic sexualization. In the present Thesis the effects of these four factors on PTSD symptomatology is tested, analyzing their interactive effects with the characteristics of the abuse, as an example of other relevant variables.

The existence and possible effects of other forms of child abuse and neglect were controlled for in all analyses carried out in the current thesis, for the effects they could have on the psychological adjustment of the victim (Grassi-Oliveira & Stein, 2008; Hazen, Connelly, Roesch, Hough, & Landsverk, 2009).

INTRODUCCIÓN

1. Prevalencia y características de los abusos sexuales a niños

1.1 Prevalencia del abuso sexual infantil

El abuso sexual infantil (ASI) incluye cualquier actividad de tipo sexual con un niño donde no hay consentimiento o éste no puede ser dado (Berliner, 2000). Incluye los contactos sexuales que se producen a través del uso de la fuerza o la amenaza de su uso, independientemente de la edad de los participantes, así como todos los contactos sexuales entre un adulto y un niño, independientemente de si hay un engaño o no o si el niño entiende la naturaleza sexual de la actividad. El contacto sexual entre un niño pequeño y otro de mayor edad puede también ser abusivo si existe una diferencia significativa de edad o desarrollo, haciendo al niño más pequeño incapaz de dar su consentimiento (Berliner y Elliot, 2002).

El ASI es común a todas las sociedades, y los estudios han informado de unas tasas en la población general de entre un 7-36%, con una prevalencia media de alrededor del 20% en las mujeres y del 8% en los hombres (Chen, Dunne y Han, 2006; Fanslow, Robinson, Crengle y Perese, 2007; Pereda, Guilera, Forns y Gómez-Benito, 2009). Por ejemplo, en un reciente metanálisis con 65 artículos conteniendo información sobre el ASI en 22 países, Pereda et al. (2009) encontraron una prevalencia media del ASI en varones del 7.4% y del 19.2% en mujeres. Además, su presencia se ha documentado tanto en países desarrollados como en vías de desarrollo (Pereda et al., 2009), aunque las tasas de prevalencia encontradas en los diferentes países y culturas varían considerablemente (Briere y Elliott, 2003; Luo, Parish y Laumann, 2008; Pereda et al., 2009; Rohde, Ichikawa, Simon, Ludman, Linde, Jeffery y Operskalski, 2008; Speizer, Goodwin, Whittle, Clyde y Rogers, 2008).

La investigación retrospectiva con estudiantes se ha planteado como una solución, al menos parcial, a los problemas relacionados con el recuerdo y la presencia de distorsiones en los estudios retrospectivos con adultos mayores (Pereda y Forns, 2007). No obstante, los resultados de estas investigaciones no han sido tampoco concluyentes (e.g., Yen, Yang, Yang, Su, Wang y Lan, 2008; Mujgan, Ethem, Oya, Deniz, Omer y Ozdemir, 2006; Oaksford y Frude, 2001; McCranna, Lalor y Katabaro, 2006; Pereda y Forns, 2007).

1.2 Características de los abusos sexuales

Aunque con alguna excepción (e. g. Briere y Elliott, 2003), los resultados de los estudios indican que la mayoría de las víctimas de ASI, entre un 54-69%, ha experimentado alguna forma de abuso sexual implicando contacto, siendo la más frecuente los tocamientos genitales (Leahy, Pretty y Tenenbaum, 2004; Oaksford y Frude, 2001; Priebe y Svedin, 2008). Las tasas de tocamientos genitales oscilan entre un 9-14% en las mujeres (Chen et al., 2004; Kendler, Kuhn y Prescott, 2004), mientras que los casos de ASI implicando penetración se sitúan entre un 1-8% (Chen et al., 2004; Kendler, Kuhn y Prescott, 2004), representando alrededor del 10-30% del total de los abusos sexuales (Leahy et al., 2004; Oaksford y Frude, 2001; Priebe y Svedin, 2008). En el ASI cometido por extraños, sin embargo, la tasa de abusos sin contacto parece ser muy superior (e.g., Gallagher, Bradford y Pease, 2008).

Alrededor de la mitad de los casos de ASI ocurren sólo una o dos veces (Fanslow et al, 2007; Oaksford y Frude, 2001), y lo más frecuente es que tengan lugar dentro del hogar del agresor o de la propia víctima. Por el contrario, los datos de Gallagher et al. (2008) sobre el ASI cometido por extraños indican que casi 2/3 de los

incidentes tuvieron lugar en calles o parques, cuando la víctima se encontraba acompañada de otros niños.

Características de los agresores

Los resultados de los estudios indican que, en la mayoría de los casos, el agresor suele ser un varón. Por ejemplo, Helweg-Larsen y Larsen (2005) sólo encontraron cinco casos de mujeres en un total de 550 fichas policiales, y todos los agresores del estudio de Oaksford y Frude (2001) eran varones. Otras investigaciones han informado de resultados similares (e.g., Mujgan, Ethem, Oya, Deniz, Omer y Ozdemir, 2006), y en su estudio sobre abusos perpetrados por extraños, Gallagher et al. (2008) encontraron que el 88,2% de los agresores eran sólo varones, mientras que en el 52,5% de los casos en los que estaba implicada una mujer también había un agresor varón.

No obstante, algunos autores sugieren que el ASI cometido por mujeres podría estar subrrepresentado (Gannon y Rose, 2008). Por ejemplo, un estudio sobre las llamadas a la *UK charity Child Line* (NSPCC, 2007) indicaba que el 5% de las niñas y el 44% de los niños manifestó que su agresor había sido una mujer. En esta misma línea, Pereda et al. (2009) concluyeron en su metanálisis que se podía estar produciendo una subestimación de los abusos cometidos por mujeres, principalmente contra niños varones (el 39% de los niños dijo que en sus abusos habían participado una mujer).

El perpetrador del abuso sexual con frecuencia es un adolescente o incluso otro niño (Gallagher et al., 2008; Oaksford y Frude, 2001; Oliver, 2007). Por ejemplo, Gallagher et al. (2008) encontraron que existía la misma probabilidad de que el extraño que cometió los abusos fuera un adulto que un menor de edad, sobre todo cuando el ASI implicaba tocamientos (agresores adultos en el 44,4% de los casos *versus* 27,8% de jóvenes y 22,2% de niños).

La mayoría de los abusos sexuales a niños y los más graves suelen cometerse dentro del contexto familiar o de su entorno próximo, es decir, los agresores son con frecuencia parientes y conocidos (Briere y Elliott, 2003; Fanslow et al., 2007; Finkelhor, Ormrod y Hamby, 2005; Leahy, et al., 2004; Pereda y Forns, 2007; Speizer et al., 2008), siendo relativamente baja la tasa de abusos cometidos por extraños (Gallagher et al., 2008; Speizer et al., 2008). Por ejemplo, en un estudio con una muestra representativa de adultos norteamericanos, Briere y Elliott (2003) informaron que un 46.8% de los abusos sexuales los había cometido alguien de la familia inmediata o extensa.

En general, los resultados indican que la forma de operar de los agresores puede cambiar en función de su edad, de las características de la víctima y de factores situacionales (Leclerc, Proulx y Beauregard, 2009). Leclerc, Carpentier y Proulx (2006) encontraron que los adultos que abusaban sexualmente de niños mayores era más probable que se sirvieran de la manipulación que de otras estrategias no persuasivas. El 18,1% de las víctimas del estudio de Pereda y Forns (2007) informó del uso de la fuerza y de las amenazas, y casi el 13% de las mujeres del estudio de McCranna et al. (2006) mencionó la fuerza física como la principal forma de persuasión. Se suele argumentar que las mujeres que abusan sexualmente de los niños utilizan menos la violencia física que los agresores varones, pero no hay pruebas consistentes al respecto (Gannon y Rose, 2008).

En la mayoría de los abusos sexuales cometidos por varones suele haber un único agresor (Fanslow et al., 2007; Gallagher et al., 2008). Por el contrario, una característica del ASI cometido por mujeres es la alta probabilidad de que lo realicen junto con un hombre (Vandiver, 2006). Por ejemplo, en una muestra nacional de

mujeres norteamericanas arrestadas por delitos sexuales, Vandiver (2006) encontró que un 54% cometió los abusos solas y un 46% con al menos un colaborador.

Características de las víctimas

En general, los estudios indican que el riesgo de sufrir abusos sexuales es de 2 a 3 veces mayor entre las niñas que entre los niños (Briere y Elliott, 2003; Chen et al., 2004; Finkelhor, 1994; Gallagher et al., 2008). En su metanálisis, Pereda et al. (2009) concluyeron que alrededor del 14% de los hombres y del 32% de las mujeres informaron de haber tenido experiencias infantiles de abuso sexual. Incluso se ha informado de diferencias aún mayores utilizando muestras nacionales o basándose en expedientes hospitalarios o policiales (Bunting, 2008; Edinburgh, Saewyc y Levitt, 2008).

Sin embargo, algunas investigaciones no han encontrado diferencias tan grandes (De Paúl, Milner y Múgica, 1995; López, 1994; McCranna et al., 2006; Pereda y Forns, 2007) o han informado de tasas similares de víctimas de uno y otro sexo (Libby, Orton, Novins, Beals y Manson, 2005; Yen et al., 2008). Hay incluso un número reducido de investigaciones que ha encontrado una mayor proporción de víctimas varones que de mujeres (McCranna et al., 2006). Finalmente, aún no se ha dilucidado cuál es el género de las víctimas más vulnerable a los abusos sexuales perpetrados por mujeres (Gannon y Rose, 2008).

Un elevado porcentaje de víctimas sufrió los abusos sexuales durante la preadolescencia, situándose la edad media de inicio del ASI entre los 9-11 años (Briere y Elliott, 2003; Chen et al., 2004; Fanslow et al., 2007; Oaksford y Frude, 2001; Pereda y Forns, 2007; Pereda et al., 2009). La bibliografía sobre abusos sexuales cometidos por

mujeres indica que las víctimas suelen ser jóvenes y preadolescentes (Vandiver y Walker, 2002).

Finalmente, diversos estudios han demostrado que las víctimas de ASI corren un mayor riesgo de volver a sufrirlo por otros agresores distintos (Gallagher et al., 2008; Pereda y Forns, 2007) y/o de ser objeto posteriormente de abusos físicos o sexuales por parte de su pareja (Fanslow et al., 2007; Speizer et al., 2008).

Revelación

La mayoría de los estudios se han centrado en si la revelación se produjo de manera intencionada o accidental, relacionándose la forma en que las víctimas revelaron el abuso sexual con diversos factores evolutivos y del abuso sexual. En el caso de los preescolares es más probable que los abusos se descubran de manera accidental, mientras que los escolares suelen revelarlos voluntariamente. La duración, frecuencia y gravedad de los abusos sexuales también influyen en la revelación, siendo más probable que la víctima los revele cuando se han prolongado durante cuatro o más meses o han sido de una menor gravedad (Cortés y Cantón, 2008). La tasa de revelación también es mayor cuando el agresor utilizó la violencia con daños físicos (e.g., Hanson, Resnick, Saunders, Kilpatrick y Best, 1999). Por el contrario, la revelación es menos probable cuando existe una relación estrecha entre la víctima y el agresor (abuso intrafamiliar *vs.* extrafamiliar) y cuando los abusos se inician a una edad más temprana (infancia *vs.* adolescencia) (e.g., Goodman-Brown, Edelstein, Goodman, Jones y Gordon, 2003; Smith, Letourneau, Saunders, Kilpatrick, Resnick y Best, 2000).

2. Consecuencias psicológicas

2.1 Consecuencias a corto plazo

Técnicamente hablando, el abuso sexual infantil no puede ser “diagnosticado” ya que no se trata de un síndrome clínico compuesto por una serie de efectos consistentes y previsibles. En lugar de eso, el ASI debe ser visto como un suceso vital o un conjunto de sucesos que pueden producir una amplia variedad de secuelas en los niños (Kuehnle, 1998). La incidencia de trastornos psicológicos a lo largo de la vida es del 57% en el caso de las mujeres y del 47% en el de los hombres con un historial de ASI. Sin embargo, el porcentaje de trastornos psicológicos cuando no existe dicho historial de ASI es significativamente inferior, de un 32% para las mujeres y de un 34% en los hombres (Sap y Vandeven, 2005).

Consecuencias en pre-escolares

La investigación acerca de las consecuencias del abuso sexual en la infancia temprana es escasa. Además, al contrario de lo que ocurre con los estudios de adultos, que se han realizado tanto con muestras clínicas como no clínicas, la información sobre los niños, con unas pocas excepciones, se ha obtenido a partir de muestras clínicas, todas ellas en contacto con servicios de protección del menor y con las autoridades judiciales (Myers, Berliner, Briere, Hendrix, Jenny y Reid, 2002).

Los principales efectos parecen ser los problemas somáticos (enuresis, encopresis, dolores de cabeza y dolores estomacales), retrasos en el desarrollo, problemas internalizantes (especialmente ansiedad y retraimiento), y especialmente,

trastorno de estrés post-traumático y conducta sexualizada (por ejemplo, masturbación excesiva o en público) (Mellon, Whiteside y Friedrich, 2006).

Todos los autores de revisiones coinciden en que el síntoma más característico en las víctimas de este grupo de edad es la expresión de algún tipo de conducta sexual considerada como anormal. Este comportamiento sexual inapropiado de los preescolares objeto de abuso sexual se ha encontrado utilizando toda una variedad de instrumentos de evaluación que van desde las valoraciones realizadas por los padres en el CBCL, la observación de juego libre con muñecos anatómicos y la evaluación de los dibujos de figuras humanas (Cortés y Cantón, 2008; Mellon et al., 2006; Tarren-Sweeney, 2008).

Consecuencias en niños de edad escolar

La investigación sobre las consecuencias es considerablemente más numerosa en este grupo de edad, apareciendo algunos nuevos hallazgos, mientras que otros son consistentes con la investigación en niños más pequeños. En el dominio físico/motor, la enuresis todavía aparece como un problema (Trickett y Putnam, 1991). Otros autores (Trickett, Noll, Reifman y Putnam, 2001) han encontrado más problemas físicos tales como dolores de estómago y de cabeza en niñas abusadas sexualmente.

En el campo socio-emocional, todavía se pueden encontrar las conductas sexuales inapropiadas y los problemas internalizantes, como ocurría con los niños más pequeños (e. g., Hébert, Tremblay, Parent, Daignault y Piché, 2006; Shipman, Zeman, Fitzgerald y Swisher, 2003).

Pero durante esta etapa pueden aparecer también una serie de problemas nuevos. Los problemas externalizantes (e. g., agresiones y problemas conductuales), trastornos disociativos, problemas en las relaciones con los iguales, desregulaciones en los niveles de cortisol y otros trastornos psicobiológicos y bajo rendimiento escolar son más

frecuentes entre niños víctimas de abuso sexual que entre niños no víctimas (Tremblay et al., 1999; Trickett, Noll, Horn y Putnam, 2001).

Consecuencias en adolescentes

La mayoría de los resultados con este grupo de edad son similares a los encontrados en niños en edad escolar. Los estudios han encontrado desregulaciones en los niveles de cortisol y otros trastornos psicobiológicos (DeBellis, Chrousos, Dorn, Burke, Helmers, Kling et al., 1994), problemas internalizantes y externalizantes (Kuhn, Arellano y Chavez, 1998), trastornos disociativos (Trickett et al., 2001), síntomas de Trastorno de Estrés Post-traumático (TEP) (Noll, Trickett, Susman y Putnam, 2006) y problemas en el rendimiento escolar y cognitivo (Boden, Horwood y Fergusson, 2007; Buckle, Lancaster, Powell y Higgins, 2005).

En muchos casos la diferencia estriba en la forma de manifestarse ciertos tipos de conducta. Así, es más probable que los adolescentes abusados sexualmente, comparados con los niños, realicen actividades delictivas, sufran trastornos de la alimentación, problemas físicos de salud, consuman drogas, lleven a cabo más conductas suicidas y auto-lesivas y conductas sexuales tempranas y de riesgo (Bailey y McCloskey, 2005; Feiring, Miller-Johnson y Cleland, 2007; Noll, Trickett y Putnam, 2003).

2.2 Consecuencias a largo plazo

En general, los estudios en los que se evalúan los efectos a largo plazo de los abusos sexuales en la infancia muestran una disminución de la sintomatología con el paso del tiempo (Lameiras, 2002). En su estudio meta-analítico, Rind, Tomovich y

Bauserman (1998) concluyeron en relación con la nocividad de estas conductas que alrededor de 2/3 de los hombres y 1/3 de las mujeres que habían mantenido actividad sexual con otros adolescentes y/o adultos durante la infancia no mostraban sintomatología clínica en la edad adulta.

Sin embargo, hay que precisar que si bien hay alguna sintomatología que remite claramente para algunas personas, especialmente aquella que tiene que ver con las manifestaciones de ansiedad (e. g., miedo, problemas para dormir), en otros casos las sintomatologías parecen agravarse, especialmente si no son tratadas inicialmente, como las que tienen que ver con las manifestaciones de agresividad o las cuestiones sexuales. Parece que el paso del tiempo no implica necesariamente la resolución del trauma en algunos casos, sino el tránsito de la sintomatología hacia formas de manifestación típicas de cada momento evolutivo (Lameiras, 2002).

Otro aspecto a tener en cuenta es la aparición de “efectos durmientes” en algunas víctimas. Un “efecto durmiente” hace referencia a la situación en la que el niño no muestra problemas significativos inmediatamente después del abuso. Sin embargo, al transcurrir el tiempo, la víctima empieza a manifestar problemas emocionales o conductuales de una etiología no clara. Los estudios iniciales identificaron la aparición de “efectos durmientes” un año después del abuso (Mannarino, Cohen, Smith y Moore-Motily, 1991). Sin embargo los estudios más recientes indican que este tipo de efectos pueden aparecer mucho más tarde de lo que inicialmente se creía. De hecho, en ocasiones la sintomatología puede surgir durante la edad adulta (Widom, 1999), debido a una revictimización o incluso en ausencia de ésta. Incluso un suceso estresante o que recuerde al abuso sufrido puede hacer aparecer la sintomatología.

Efectos emocionales

De acuerdo con Berliner y Elliot (2002), la depresión es uno de los síntomas más frecuentes en adultos abusados sexualmente durante la infancia. Ferguson, Boden y Horwood (2008), por ejemplo, llevaron a cabo un estudio longitudinal durante 25 años con más de 1000 niños, evaluando los efectos del ASI y del maltrato físico sobre el ajuste psicológico. Estos autores encontraron un efecto muy superior del ASI que del maltrato físico, siendo una de las principales consecuencias del abuso sexual la mayor tasa del trastorno depresivo entre las víctimas.

El historial de ASI se suele relacionar también con síntomas de ansiedad en la etapa adulta, tanto con muestras clínicas como comunitarias (Gold, Lucenko, Elhai, Swingle y Sellers, 1999; Hooper y Warwick, 2006). Las víctimas de abuso sexual presentan una probabilidad hasta 5 veces mayor que el resto de la población de ser diagnosticada de al menos un trastorno de ansiedad como trastorno de ansiedad generalizada, fobias, trastorno de pánico o trastorno obsesivo compulsivo (Berliner y Elliott, 2002).

Levitan, Rector, Sheldon y Goering (2003) dividieron una muestra de 6597 participantes de entre 15 y 64 años en 4 grupos: controles normales, participantes con depresión pero sin trastornos de ansiedad, participantes con uno o más trastornos de ansiedad pero sin depresión y participantes con depresión y ansiedad comórbidas. Los autores encontraron una fuerte asociación entre el haber sido víctima de ASI y el padecer ansiedad y depresión comórbidas, pero no como trastornos aislados.

Otro síntoma común entre los adultos que fueron víctimas de ASI es la baja autoestima (Johnson, Rew y Kouzekanani, 2006). Cantón y Justicia (2008) llevaron a cabo un estudio con una muestra de 83 estudiantes universitarios víctimas de ASI, encontrando que el historial de ASI se relacionaba con una baja autoestima. Aquellos

participantes víctimas de abuso sexual presentaban un incremento del 21% en la probabilidad de sufrir problemas de autoestima.

Whealin y Jackson (2002) trataron de examinar la relación existente entre la atención sexual no deseada durante la infancia y una serie de medidas de auto concepto en la actualidad en 448 mujeres jóvenes. Los autores encontraron que la frecuencia de atención sexual no deseada durante la infancia se encontraba asociada con un pobre auto concepto académico, de apariencia física, de imagen corporal, de ansiedad por el cuerpo y auto estima global.

Efectos en la sexualidad

En general los investigadores han encontrado que las mujeres con un historial de ASI presentan una mayor probabilidad que las mujeres sin ese historial de llevar a cabo prácticas sexuales no sanas o mal adaptativas (e. g., evitación del sexo, prácticas sexuales de riesgo), tienen relaciones sexuales con una menor frecuencia y experimentan una serie de problemas y disfunciones sexuales (Merril et al., 2003; Randolph y Reddy, 2006). Sin embargo, el bienestar sexual de las mujeres que han experimentado ASI no se puede comprender completamente sin tener en cuenta sus experiencias subjetivas o sus evaluaciones cognitivo-afectivas respecto a la sexualidad. Algunas mujeres que son capaces de responder físicamente a la estimulación podrían no valorar su activación sexual de forma positiva; sus evaluaciones cognitivo-afectivas de su respuesta física podrían evocar sentimientos de culpa o vergüenza. Por el contrario, otras mujeres que informan de problemas sexuales pueden describir también sentimientos de placer o satisfacción sexual (Lemieux y Byers, 2008).

Lemieux y Byers (2008) examinaron la relación entre el ASI y una serie de aspectos del bienestar sexual en mujeres. La muestra estuvo compuesta por 270 mujeres

universitarias de entre 17 y 49 años, un 27% de las cuales habían sufrido ASI y un 14% agresiones sexuales entre los 13 y 16 años. El hecho de haber sido víctima de ASI o agresiones sexuales consistentes en tocamientos no se relacionaba con consecuencias sexuales negativas. Sin embargo, las mujeres que habían experimentado ASI o agresiones que implicaban penetración o intento de penetración presentaban un mayor riesgo de sufrir revictimización sexual, relaciones sexuales ocasionales más frecuentes y menos satisfactorias, relaciones sexuales sin protección de forma más frecuente, períodos de evitación del sexo y una menor autoestima sexual.

También se ha observado la existencia de un mayor riesgo en mujeres víctimas de ASI de ejercer la prostitución. En un estudio llevado a cabo por Vaddiparti, Bogetto, Callahan, Abdallah, Spitznagel y Cottler (2006) con una muestra de 594 mujeres alcohólicas y consumidoras de drogas, estos autores encontraron una relación entre dedicarse a la prostitución y el haber sido forzada a tocar o besar a alguien de un modo sexual antes de los 15 años (35% *vs.* 22%), el haber sido tocada o besada sin quererlo (42% *vs.* 31%), y el haber sido forzada a tener relaciones sexuales (30% *vs.* 21%).

Problemas en las relaciones interpersonales y crianza de los hijos

El ASI puede dar lugar no solamente a trastornos físicos y psicológicos, sino que también puede afectar a la percepción de sí mismas de las víctimas en las relaciones con los otros (Romano y DeLuca, 2001). Problemas interpersonales comunes de las víctimas incluyen dificultades para iniciar, mantener y desarrollar relaciones interpersonales (Larson, Newell Holman y Feinauer, 2007), así como dificultades para confiar en los demás (Davis y Petretic-Jackson, 2000). Estas dificultades son causadas por la traición generada por el ASI, que llevaría a la víctima a evitar las relaciones interpersonales por

miedo al abandono o para evitar otra violación de la confianza, o a tratar agresivamente de controlar a los demás (Larson et al., 2007).

Los efectos a largo plazo del ASI pueden, a su vez, influir sobre una serie de dimensiones de las relaciones de pareja como la estabilidad de las relaciones o la percepción de la preparación para el matrimonio. Larson et al. (2007) analizaron como el abuso sexual extrafamiliar puede afectar negativamente a la calidad de las relaciones de pareja y la preparación para el matrimonio en hombres víctimas de ASI. Una muestra de 142 víctimas de abuso y 142 no víctimas de características sociodemográficas similares completaron el "Preparation for Marriage Relationship Questionnaire" (PREP-M). Los resultados mostraron que, en comparación con los hombres no abusados, era más probable que las víctimas de ASI fueran solteros o en relaciones de pareja menos avanzadas (e. g. comprometidos). También informaban de unas relaciones de pareja menos estables y satisfactorias y mostraban una menor empatía hacia sus parejas.

Por otra parte, las mujeres que durante su infancia fueron objeto de abusos sexuales suelen informar de dificultades en la crianza de sus propios hijos. Cohen (1995) realizó un estudio comparando las habilidades de crianza de 26 madres que fueron víctimas de abuso sexual infantil con las de un grupo de control. El autor encontró que las madres que habían sido víctimas de incesto se caracterizaban por haber recibido menos apoyo en la crianza de los hijos y por presentar un nivel inferior de habilidades de comunicación y de autoimagen de su rol materno.

Otra consecuencia que se ha relacionado con el ASI ha sido el mayor riesgo de revictimización, entendiendo como tal el posterior abuso sexual o físico de la víctima cuando adulta. La experiencia de revictimización puede combinarse e incrementar los efectos del ASI. Filipas y Ullman (2006), por ejemplo, en una muestra de estudiantes universitarias, encontraron que un 42.2% de las mujeres que informaron de una

experiencia de abuso sexual infantil informaron además de una agresión sexual durante la edad adulta, mientras que únicamente un 14% de las que no habían sufrido abuso sexual informaron de dichas agresiones sexuales.

Disfunciones conductuales

Los estudios empíricos han confirmado la existencia de una relación entre el ASI y el consumo de drogas y alcohol durante la etapa adulta. Wilson y Widom (2009), por ejemplo, realizaron un estudio longitudinal, con 896 participantes, para comprobar la posible relación entre el abuso sexual, físico y negligencia y el consumo de drogas en la edad adulta media. Esta relación se daba únicamente en el caso de las mujeres, estando mediatizada por los problemas en la escuela, la delincuencia y la prostitución. Las autoras plantearon que, el hecho de encontrar esta relación únicamente en el caso de las mujeres se podría deber a un "efecto de saturación" o "efecto techo". Dado que los hombres generalmente presentan un mayor riesgo que las mujeres de consumo de drogas, el riesgo adicional asociado a estos factores debe ser mínimo (Widom, Marmostein y White, 2006).

Los estudios también han encontrado una relación entre el ASI y las conductas delictivas, incluyendo crímenes contra la propiedad, conductas agresivas y violencia (Baron, 2004). Sigfusdottir, Asgeirsdottir, Gudjonsson y Sigurdsson (2008), por ejemplo, investigaron esta relación en una muestra de 9,113 estudiantes universitarios, controlando la estructura familiar y el nivel educativo de los padres. Encontraron una mayor probabilidad de delinquir entre las víctimas de ASI, estando esta relación mediatizada por el nivel de depresión y, especialmente, de rabia.

El ASI también incrementa el riesgo de llevar a cabo intentos de suicidio (Johnson et al., 2006). Eisenberg, Ackard y Resnick (2007) dividieron una muestra de

83,731 estudiantes de instituto en cuatro grupos: sin un historial de ASI, víctimas de un miembro de su familia, víctimas de un agresor extrafamiliar y víctimas de ambos. Las variables dependientes fueron tanto la ideación suicida como los intentos de suicidio. El 4% de los estudiantes informó de haber sufrido ASI extrafamiliar, el 1.3% intrafamiliar y el 1.4% ambos. Los análisis mostraron que las víctimas de abuso sexual en la infancia presentaban un mayor riesgo de realizar conductas suicidas que otros jóvenes.

La evidencia también sugiere que es más probable que los menores que han sufrido abuso sexual abusen de otros niños que el resto de la población (Craissati, McClurg y Browne, 2002). Bagley, Wood y Young (1994), por ejemplo, entrevistaron a 750 hombres de entre 18 y 27 años acerca de contactos sexuales no deseados ocurridos antes de los 17 años. El 16% de la muestra informó de una o más de estas experiencias. Casi la mitad de éstos (44%) había sufrido múltiples incidentes de abuso sexual. Este último grupo difería de todos los demás, mostrando unas mayores tasas de interés o de conductas sexuales con menores. Se encontró que haber sido víctima de abuso emocional durante la infancia, en combinación con haber sufrido múltiples incidentes de victimización sexual era un fuerte predictor de tener interés o haber llevado a cabo conductas sexuales con menores durante la edad adulta.

Problemas físicos y de salud

Los estudios realizados sugieren una relación causal entre el ASI y la aparición de problemas graves de salud física como trastornos somáticos, dolores crónicos y trastornos gastrointestinales y de la alimentación (Cachelin, Schug, Juarez y Monreal, 2005; Bonomi, Cannon, Anderson, Rivara y Thompson, 2008).

Bonomi et al. (2008), en un grupo de 3,568 mujeres de entre 18 y 64 años, evaluaron la relación entre el haber sufrido abuso sexual o físico antes de los 18 años y

la salud mental y física en la actualidad. Encontraron que aquellas mujeres que habían sufrido ambos tipos de abuso eran las que presentaban un peor ajuste mental y físico (mayor depresión y síntomas físicos como nauseas, dolor de articulaciones, problemas gastrointestinales, fatiga…). Las mujeres víctimas únicamente de abuso físico o sexual presentaban una mayor prevalencia de trastornos físicos, aunque las asociaciones no eran tan fuertes.

Cachelin et al. (2005) examinaron la asociación entre el ASI y los trastornos de la alimentación en una muestra comunitaria de mujeres mejicanas. Compararon 80 casos de trastornos de la alimentación con 110 participantes sanos respecto a la presencia del abuso sexual y sus características. Los resultados indicaron que, en comparación con los controles, era más probable que los casos de trastornos de la alimentación informaran de abuso sexual y hubieran experimentado abusos de mayor duración.

Trastornos de personalidad y disociativos

Junto con el TEP, la disociación parece ser una respuesta frecuente a los sucesos altamente traumáticos, y a menudo aparece en víctimas adultas de ASI (Zanarini, Ruser, Frankenburg, Hennen y Gunderson, 2002). Se piensa que la disociación es un mecanismo de defensa contra los pensamientos, sentimientos y conductas relativas al abuso. En el caso de abusos especialmente graves, el trauma puede hacer difícil que la víctima integre cognitivamente el suceso, reforzando un mecanismo de reducción de la conciencia sobre el trauma. La habilidad de las víctimas para disociar los pensamientos, sentimientos y memorias específicos del abuso permite una reducción del impacto de la victimización cambiando la naturaleza o el grado del dolor relacionado con el abuso (Berliner y Elliott, 2002). Sin embargo, aunque la disociación puede mejorar el

funcionamiento conductual y psicológico y por lo tanto ser una defensa frente al trauma, puede también tener consecuencias negativas a largo plazo en la adaptación, y disminuyendo la capacidad de la víctima para cuidar de sí misma e interfiriendo en los procesos cognitivos adaptativos (Briere, 1996).

Las investigaciones también han encontrado una relación entre un historial de ASI y el desarrollo de trastornos de personalidad, especialmente el trastorno borderline de la personalidad (e. g., Katerndahl, Burge y Kellogg, 2005), pero también otros trastornos de la personalidad como el antisocial, dependiente, evitativo y esquizoide (Allen, Coyne y Huntoon, 1998; Weiler y Widom, 1996).

Trastorno de Estrés Post-traumático

El malestar psicológico que se produce como reacción a un suceso traumático a menudo se manifiesta a través de: a) pesadillas, flashbacks y pensamientos intrusivos sobre el abuso; b) evitación; y c) activación del sistema autónomo (Berliner y Elliot, 2002). Numerosos estudios han demostrado que el Trastorno de Estrés Post-traumático (TEP) es una de las consecuencias a largo plazo más frecuentes del abuso sexual en la infancia, y que a menudo aparece junto a otros problemas emocionales (Butzel, Talbot, Duberstein, Houghtalen, Cox y Giles, 2000; Choi, Klein, Shin y Lee, 2009; Kingston y Raghavan, 2009; Plotzker, Metzger y Holmes, 2007; Putnam, 2003; Widom, 1999). Según diversos autores, los porcentajes de TEP en muestras de víctimas de ASI han llegado hasta el 36% (Berliner y Elliot, 2002)

Widom (1999), por ejemplo, informó que un 37.5% de una muestra de 96 adultos víctimas de ASI cumplían los criterios para el diagnóstico de TEP. Los síntomas específicos de este TEP tardío incluyen los flashbacks, pensamientos intrusivos,

sobreactivación fisiológica, distorsiones cognitivas y evitación de situaciones o estímulos que pueden, de algún modo, recordar al abuso.

Plotzker, Metzger y Holmes (2007) también demostraron la existencia de una relación entre el ASI y el diagnóstico de TEP. Estos autores, en una muestra de 113 mujeres toxicómanas, comprobaron la relación existente entre el ASI y el maltrato físico en la infancia, y las conductas de riesgo relacionadas con el sexo o las drogas (e. g. compartir jeringas), la depresión y el TEP. Un 56% de la muestra había sufrido ASI y un 68% maltrato físico en la infancia. Los autores encontraron que, al contrario que el maltrato físico, el tener un historial de ASI relacionaba con la depresión y el TEP; además, éste último mediatizaba la relación entre el ASI y las conductas de riesgo.

Recientemente, Choi, Klein, Shin y Lee (2009) encontraron, en una muestra de 46 mujeres dedicadas a la prostitución, que el haber experimentado ASI incrementaba la probabilidad de desarrollar síntomas de estrés post-traumático, especialmente entre aquellas mujeres víctimas de agresores cercanos. Finalmente, Kingston y Raghavan (2009) también encontraron en una muestra de jóvenes de entre 12 y 17 años que el haber sufrido ASI se relacionaba, además de con un mayor riesgo de sufrir otras experiencias traumáticas y llevar a cabo conductas de riesgo, con una mayor probabilidad de sufrir TEP.

3. Factores intervinientes en los efectos del abuso sexual infantil

Aunque la mayoría de los estudios que han examinado las secuelas a largo plazo del ASI señalan numerosas dificultades psicológicas, conductuales y sociales en la edad adulta, no hay pruebas de que exista un grupo consistente de síntomas que configuren un “síndrome post-abuso”, y no todas las víctimas de abuso infantil muestran un daño

significativo posterior (Jonzon y Lindblad, 2006). Reconociendo que no todas las experiencias de ASI son iguales, algunos investigadores han empezado a examinar las variables que explicarían las diferencias en el ajuste posterior.

3.1 Características del abuso, víctima y agresor

El impacto de los abusos sexuales se puede deber, al menos en parte, por sus propias características. Así, se han estudiado una serie de variables como el tipo de abuso, su frecuencia y duración, la relación con el agresor, el sexo y edad de éste, el uso de la fuerza, el número de agresores y el sexo y edad de la víctima.

Los resultados indican que las consecuencias son más graves cuando los abusos se han producido con más frecuencia y prolongado durante más tiempo (Chromy, 2006; Hébert, Tremblay, Parent, Daignault y Piché, 2006; Steel, Sanna, Hammond, Whipple y Cross, 2004), el agresor ha recurrido al empleo de la fuerza (Weaver, Chard, Mechanic y Etzel, 2004), se han realizado actos más graves, incluyendo la penetración (Collin-Vézina y Hébert, 2005; Gamble, Talbot, Duberstein, Conner, Franus, Beckman y Conwell, 2006; Lemieux y Byers, 2008) y cuando existe una relación más próxima entre víctima y perpetrador (Hébert, Tremblay, Parent, Daignault y Piché, 2006; Ullman, 2007), sobre todo si se trata de una relación incestuosa con el padre o padrastro (McLean y Gallop, 2003; Tyler, 2003).

Hay que tener también en cuenta que muchos niños experimentan más de un tipo de abuso, habiéndose demostrado que las víctimas de abusos sexuales que también son objeto de maltrato físico presentan más problemas. Por ejemplo, Luster y Small (1997) encontraron, que cuando las chicas objeto de ASI también habían sufrido malos tratos físicos sus puntuaciones en consumo de alcohol eran el doble de las obtenidas por las

víctimas sólo de abusos sexuales. El papel moderador del maltrato físico era especialmente fuerte entre las adolescentes que continuaban sufriendo abusos sexuales. Los resultados obtenidos con la muestra de varones indicaban también que el maltrato físico aumentaba en mayor medida el riesgo de ideas suicidas entre las víctimas de abuso sexual, especialmente entre los adolescentes que continuaban siendo objeto de abusos sexuales.

Los estudios que han investigado las diferencias de género sugieren que es menos probable que los hombres que han sufrido ASI sufran ansiedad, depresión y TEP que las mujeres, pero es tan o más probable que sean diagnosticados de trastorno antisocial de la personalidad o que tengan problemas de abuso de sustancias y consumo de alcohol (Denov, 2004; Gault-Sherman, Silver y Sigfúsdóttir, 2009; Ullman y Filipas, 2005). Otras investigaciones han informado que los hombres abusados sexualmente en la infancia cometen más intentos de suicidio y muestran mayores tasas de ideación suicida que las mujeres (Luster y Small, 1997). Por último, los estudios también han comprobado que estos hombres llevan a cabo más conductas sexuales de riesgo, como un inicio temprano de las relaciones y un uso menos frecuente de métodos anticonceptivos, que las mujeres (Chandy et al., 1996).

Los estudios que han analizado el impacto del abuso sexual en función del sexo del agresor son escasos debido a que son muy pocas las mujeres responsables de abusos sexuales revelados. Russell (1986) informó en un estudio comunitario que los adultos que habían sido objeto de abusos sexuales en su infancia consideraban las experiencias tenidas con hombres más traumáticas aquellas con mujeres.

Tampoco ha proliferado la investigación sobre el papel de la edad del agresor en los efectos del ASI. Russel (1986) encontró que los sujetos informaban sentirse menos traumatizados cuando el abuso lo había realizado una persona menor de 26 años o

mayor de 50. En general, los estudios realizados han confirmado que los abusos sexuales cometidos por adolescentes les resultan menos traumatizantes a las víctimas que los efectuados por adultos (Sperry y Gilbert, 2005).

La revelación, es decir, el proceso por el que los abusos sexuales se llegan descubrir, también puede tener consecuencias a corto y largo plazo. Kogan (2005) informó que una revelación temprana del abuso amortiguaba sus efectos sobre una serie de síntomas, además de sobre una futura victimización sexual. Ullman (2007), por su parte, encontró que las víctimas de familiares presentaban más síntomas de TEP si, además de haber recibido más reacciones negativas en la infancia y de sentirse más culpables en el momento del abuso, habían retrasado la revelación.

Sin embargo, algunos estudios no han encontrado una relación entre las características del abuso y el ajuste de las víctimas. Por ejemplo, Quas, Goodman y Jones (2003), encontraron que ni la gravedad, duración, frecuencia, uso de la fuerza o edad de inicio se relacionaban con las consecuencias del abuso después de 5 años. Tampoco Paolucci et al. (2001), encontraron una asociación entre la relación del agresor con la víctima y las consecuencias del abuso. Los resultados de estas investigaciones sugieren que otros factores podrían estar influyendo sobre el ajuste de las víctimas de ASI.

Además, aunque la diversidad en la experiencia del abuso se relaciona con las diferencias observadas en sus efectos, solamente una pequeña parte de la variabilidad en las consecuencias se puede atribuir a las características del acto abusivo. Y lo que es más, aunque estas características pueden ayudarnos a identificar cuáles son las víctimas con mayor riesgo de dificultades de adaptación, al ser fijas y no poder ser objeto de intervención, su utilidad clínica es muy limitada. Consiguientemente, el estudio de los procesos o mecanismos que explican el desarrollo de una determinada sintomatología

resulta de mayor utilidad para diseñar una intervención eficaz (Chaffin, Wherry y Dykman, 1997).

3.2 Factores situacionales

Ambiente familiar

La disfunción familiar no sólo puede aumentar la probabilidad de que se produzcan abusos sexuales intrafamiliares, sino también acentuar sus efectos una vez producidos. Las víctimas de abusos sexuales experimentan un mayor nivel de estrés cuando existe un funcionamiento familiar negativo, más conflictos y menos cohesión. Por el contrario, si el niño mantiene una relación de apoyo con los miembros de su familia, los efectos negativos del abuso pueden disminuir (Eisenberg, Ackard y Resnick, 2007). La familia puede ayudar a la víctima a evitar futuros problemas escuchando, creyendo la historia, expresando su apoyo y ánimo, mostrando su amor y creando una atmósfera abierta para el procesamiento del trauma (Larson, Newell, Holman y Feinauer, 2007).

McClure, Chavez, Agars, Peacock y Matosian (2008) encontraron que las características familiares (conflicto familiar y cohesión) explicaban el 13-23% de la varianza en las medidas de bienestar (auto aceptación, habilidad para establecer relaciones y dominio sobre el ambiente). Por el contrario, las características del abuso explicaron únicamente el 3% o menos de la varianza. Eisenberg et al. (2007) investigaron una muestra de 83,731 estudiantes de instituto dividida en cuatro grupos: sin un historial de ASI, víctimas de un miembro de su familia, víctimas de un agresor extrafamiliar y víctimas de ambos. El 4% de los estudiantes informó de haber sufrido ASI extrafamiliar, el 1.3% intrafamiliar y el 1.4% ambos. Aunque los jóvenes con un

historial de ASI presentaban un mayor riesgo de conductas suicidas que otros jóvenes, al tener en cuenta ciertos factores protectores (unión familiar, el cuidado por parte del profesor y el cuidado por parte de otros adultos) la probabilidad de llevar a cabo conductas suicidas disminuía considerablemente, especialmente al controlar el grado de unión familiar.

Apoyo social

Un gran cuerpo de evidencia apoya la hipótesis de que el apoyo social tiene un efecto amortiguador sobre las consecuencias negativas del abuso en niños y víctimas adultas. Marivate y Madu (2007) examinaron los efectos del nivel de apoyo social sobre el ajuste psicológico de víctimas adultas de ASI. Quinientos estudiantes de dos universidades de Sudáfrica participaron en este estudio (115 hombres y 383 mujeres), en el que los resultados mostraron que cuanto mayor era el nivel de apoyo social recibido por las víctimas de ASI mejor era el ajuste psicológico.

Hyman, Gold y Cott (2003), por su parte, trataron de distinguir los tipos específicos de apoyo social percibido que amortiguan el desarrollo de TEP en víctimas de ASI. Ciento setenta y dos mujeres adultas víctimas de ASI respondieron el "Interpersonal Support Evaluation List" (ISEL), que evalúa la disponibilidad percibida de 4 tipos de apoyo social: tangible (disponibilidad percibida de ayuda material), evaluación (disponibilidad percibida de alguien con quien hablar), autoestima (disponibilidad percibida de una comparación positiva con otros) y pertenencia (disponibilidad percibida de una compañía con la que poder disfrutar de actividades). También respondieron el "Impact of Events Scale" (IES), para evaluar los síntomas de TEP de evitación e intrusión. Los análisis demostraron que el apoyo social amortiguaba el desarrollo de TEP, a través especialmente del apoyo de autoestima y de evaluación.

Factores relacionados con la intervención del sistema

Los profesionales e investigadores del ASI han planteado algunos interrogantes sobre el posible impacto que la intervención del sistema puede tener en las vidas de estos niños (e.g., Henry, 1997). La investigación y consiguiente intervención en un caso de abuso sexual conlleva la implicación en el mismo de diversos sistemas sociales (servicios sociales de protección infantil, policía judicial, juzgados de menores, juzgados de lo penal), cada uno con sus objetivos específicos. Esto supone que el niño se va a ver involucrado en varias intervenciones simultáneamente, a pesar de que muchas veces carece (por su edad, efectos evolutivos del trauma y la falta de apoyo familiar) de los recursos cognitivos, afectivos y sociales necesarios para afrontar esta situación. Además, el sistema a menudo requiere no solo que el niño tenga que repetir durante entrevistas con distintos profesionales una información que le resulta dolorosa, sino que también se puede ver obligado a salir de su hogar y tener que ver al agresor en el juzgado y mientras testifica. La falta de una relación de confianza con los profesionales también puede hacer que se sienta especialmente vulnerable: El aislamiento personal aumenta el miedo a lo desconocido, la supresión de sentimientos y el retraimiento emocional, socavando los sentimientos de autoeficacia (Cortés y Cantón, 2008).

Los escasos estudios realizados sobre el impacto de la intervención del sistema social se han centrado, fundamentalmente, en las posibles consecuencias negativas que pueden tener para el niño el someterse a múltiples entrevistas por distintos entrevistadores y el tener que testificar. La realización de múltiples entrevistas por distintos profesionales parece incrementar los síntomas, mientras que no ocurre así cuando es un único profesional el encargado de entrevistar a la víctima en diversas

sesiones (Berliner y Elliott, 2002). La declaración en un juicio penal se ha relacionado con un incremento en el estrés interno, ansiedad o salud mental posterior cuando tiene que testificar en más de una ocasión o la sesión resulta dura y prolongada (Henry, 1997). No obstante, cuando se le prepara adecuadamente para su comparecencia, el estrés psicológico experimentado es menor. También se produce un incremento de esta sintomatología cuando la víctima tiene que pasar por un examen médico o está esperando la comparecencia para testificar (Henry, 1997).

3.3 Variables cognitivas de la víctima

Como Williams (1993) ha sugerido, personas con experiencias abusivas similares pueden sufrir consecuencias diferentes "dependiendo de cómo se perciban, evalúen y procesen los sucesos". Así, se han estudiado ciertas diferencias individuales en el procesamiento cognitivo de la experiencia abusiva, tales como el estilo de afrontamiento (Walsh, Fortier y DiLillo, 2010), las atribuciones de responsabilidad (Filipas y Ullman, 2006) o los sentimientos provocados por el abuso (Feiring, Simon y Cleland, 2009), por su papel en la recuperación tras el ASI.

Estrategias de afrontamiento

Las estrategias de afrontamiento son definidas como "esfuerzos cognitivos y conductuales constantemente cambiantes para hacer frente a demandas internas o externas" (Lazarus y Folkman, 1993). Lazarus y Folkman (1993) ya sugirieron la importancia del afrontamiento ante acontecimientos de tipo estresante, como es el ASI, considerándolos un mediador en la relación entre el suceso estresante y sus consecuencias emocionales. Desde su perspectiva de procesos, el afrontamiento no es

un estilo global, sino un conjunto de estrategias específicas empleadas por la persona ante un suceso específico.

En la actualidad se emplean numerosas taxonomías de estilos de afrontamiento, lo que hace difícil las comparaciones entre estudios, debido al empleo de etiquetas diferentes para estas estrategias. El modelo predominante para clasificar las estrategias empleadas en el afrontamiento del abuso es el de aproximación-evitación, según el cual, los pensamiento y/o acciones se pueden dirigir hacia una amenaza (aproximación) o a alejarse de ella (evitación) (Merrill, Thomsen, Sinclair, Gold y Milner, 2001).

La mayoría de los estudios que han examinado el efecto de diferentes estrategias han encontrado una relación entre las estrategias de evitación (e. g., negación, distanciamiento, aislamiento social) y un peor ajuste psicológico tras el ASI (Filipas y Ullman, 2006; Hébert, et al., 2006; Rosenthal, Rasmussen, Palm, Batten y Follette, 2005; Sullivan, Meese, Swan, Mazure y Snow, 2005; Wright, Crawford y Sebastian, 2007). Sin embargo, algunos investigadores no han encontrado esta relación, o incluso han hallado una relación inversa, asociándose el empleo de las estrategias de afrontamiento de evitación con un mejor ajuste psicológico. Por ejemplo, Chaffin, Wherry y Dykman (1997) informaron que aunque el empleo de estrategias de afrontamiento por evitación en niños de edad escolar predecía una mayor ansiedad sexual, también se relacionaba con menos problemas conductuales según sus padres.

Por otra parte, las estrategias aproximativas (e. g., tratar de ver la situación desde un punto de vista diferente, búsqueda de apoyo social) se han asociado a un mejor ajuste psicológico (Bal, Van Oost, De Bourdeaudhuij y Crombez, 2003; Merril et al., 2001; Runtz y Schallow, 1997; Steel et al., 2004). No faltan, sin embargo, los estudios que no han encontrado esta relación (Filipas y Ullman, 2006; Hébert et al., 2006; Shapiro y Levendosky, 1999; Tremblay, Hebert y Piché, 1999; Walsh et al., 2010), o incluso que

han hallado una relación inversa (Brand y Alexander, 2003; Burt y Katz, 1987; Daigneault, Hébert y Tourigny, 2006).

Filipas y Ullman (2006), por ejemplo, llevaron a cabo un estudio con un grupo de 577 estudiantes universitarias, de las que un 28% había sufrido abuso sexual en la infancia, y encontraron que las estrategias de afrontamiento de evitación, consideradas por los autores como no adaptativas, aumentaban el riesgo de revictimización, así como de desarrollo de TEP. Sin embargo, las estrategias aproximativas, consideradas como adaptativas, (conseguir ayuda de otros hablando de la experiencia, ir a un terapeuta), no se relacionaban con ninguna de las dos consecuencias del abuso evaluadas.

Finalmente, Daigneault et al. (2006) incluso informaron de una relación negativa entre el empleo de estrategias aproximativas y un peor ajuste psicológico en una muestra clínica de 103 mujeres adolescentes víctimas de ASI. El afrontamiento de evitación se relacionaba con la depresión, mientras que el afrontamiento de aproximación (búsqueda de apoyo social y reevaluación positiva), por el contrario, se asociaba a una mayor preocupación sexual.

Estilo atribucional

Otro factor cognitivo estudiado como un posible mediador entre el ASI y el ajuste psicológico han sido las atribuciones de culpa por el abuso. El abuso sexual motiva una búsqueda de significado para dar sentido a las experiencias que violan las creencias en un mundo seguro y justo. La comprensión del abuso y sus consecuencias implica hacer una serie de atribuciones causales acerca de por qué ocurrió el abuso (Feiring y Cleland, 2007).

El estilo atribucional se refiere a la tendencia de un individuo a hacer inferencias causales acerca de una situación (Seligman, Abramson, Semmel y von Baeyer, 1979).

Un individuo con un estilo atribucional negativo adscribe las causas de los sucesos negativos a sí mismo (internas), a través de las situaciones (globales) y del tiempo (estables). La mayor parte de los estudios sobre las atribuciones de culpa en víctimas de ASI se han centrado en la dirección (interna o externa) de dichas atribuciones, demostrando incluso algunos estudios como el realizado por Barker-Collo (2001) que no existe una relación entre las dimensiones de estabilidad y globalidad del estilo atribucional y el ajuste psicológico.

Teóricamente, la víctima puede atribuir la responsabilidad del abuso a ella misma, al agresor y/o a otros adultos. El énfasis de la investigación, sin embargo, ha estado centrado en las atribuciones de autoinculpación (McMillen y Zuravin, 1997). Los resultados de los estudios han indicado que este tipo de atribuciones se asocian a un peor ajuste psicológico (e. g., Filipas y Ullman, 2006; Steel et al., 2004). Steel et al. (2004), por ejemplo, encontraron que la auto inculpación se relacionaba con un mayor malestar psicológico, reflejado a través de las puntuaciones en el SCL-90-R. Filipas y Ullman (2006) estudiaron los efectos sobre el TEP de las atribuciones de auto inculpación en el momento del abuso y la autoinculpación actual como consecuencia del abuso sufrido en la infancia. Los autores encontraron que únicamente las atribuciones actuales predecían la sintomatología de TEP. Sin embargo, no todos los estudios han encontrado esa relación entre las atribuciones de autoinculpación en la edad adulta y el ajuste psicológico de la víctima (e. g., Barker-Collo, 2001).

La inculpación a la familia también se ha asociado a un peor ajuste (McMillen y Zuravin, 1997). McMillen y Zuravin (1997) encontraron que este tipo de atribuciones se asociaban a una mayor probabilidad de tener un hijo víctima de maltrato y a una mayor ansiedad en las relaciones. Sin embargo, la mayoría de los estudios no han encontrado una asociación entre la inculpación al agresor y el bienestar psicológico de las víctimas

(e. g., Feiring y Cleland, 2007; McMillen y Zuravin, 1997), a pesar del énfasis de las intervenciones clínicas en estimular las atribuciones de culpa hacia el agresor.

La evaluación de las atribuciones ha sido la limitación más grave y consistente de los estudios (McMillen y Zuravin, 1997). Algunos investigadores han categorizado respuestas a preguntas abiertas en categorías mutuamente excluyentes de culpa (e. g., Perrot, Morris, Martin y Romans, 1998). Otros han empleado un único ítem para evaluar las atribuciones de culpa (e. g., Steel et al., 2004), lo que podría no representar adecuadamente las diferentes formas en que la víctima puede culparse a sí misma o a otras personas. Por último, otros han evaluado diferentes tipos de atribuciones de culpa, incluyendo la inculpación a sí mismo, al agresor o a la sociedad, pero con escalas de un único ítem (Filipas y Ullman, 2006).

Sentimientos provocados por el abuso

Según Finkelhor y Browne (1985), son cuatro los sentimientos provocados por el ASI (traición, estigmatización, indefensión y sexualización traumática) que median entre la experiencia de abuso y su impacto psicológico. Estos autores hipotetizaron que estas dinámicas distorsionan el autoconcepto, la visión sobre el mundo y las capacidades afectivas de la víctima, provocando el desarrollo de diversos problemas psicológicos.

De acuerdo con este modelo teórico, el sentimiento de traición consiste en la dinámica por la que el niño descubre que una persona en la que confía y con la que tiene una fuerte relación de dependencia le ha causado un daño. La desilusión y la pérdida de una figura en la que se confiaba podrían provocar sentimientos depresivos, cólera y la desconfianza hacia las personas en situaciones posteriores.

La estigmatización se refiere al proceso por el que trasladan al niño una serie de connotaciones negativas asociadas al abuso (maldad, vergüenza, culpa), incorporándose luego a su autoimagen. La estigmatización puede llevar a una baja autoestima, conductas autolesivas, ideas de suicidio y la identificación con otros niveles estigmatizados de la sociedad (drogadicción, prostitución).

La indefensión es el proceso dinámico por el que la voluntad, deseos y sentido de la eficacia del niño son consistentemente anulados al invadir de forma reiterada el territorio y espacio corporal de la víctima en contra de su voluntad, reforzándose así su autopercepción como víctima. El sentimiento de indefensión puede relacionarse con el miedo y la ansiedad y con reacciones compensatorias que tienen su origen en la necesidad extrema de controlar o dominar y que le pueden llevar a abusar sexualmente de otros. También puede afectar a las habilidades de afrontamiento de la víctima, de forma que esta se sienta incapaz de hacer frente a los problemas del ambiente.

Finalmente, la sexualización traumática se refiere al proceso por el que el abuso sexual configura la sexualidad del niño, incluidos sus sentimientos y actitudes sexuales, de una forma evolutivamente inadecuada y disfuncional. El resultado será el desarrollo de una conducta promiscua o de una aversión hacia el sexo.

Sin embargo, la práctica totalidad de los estudios que han intentado comprobar empíricamente este modelo se han centrado exclusivamente en una dinámica aislada (e. g., Feiring y Cleland, 2007; Feiring, et al., 2009; Kim, Talbot y Cicchetti, 2009). Hasta la fecha, solamente unos pocos estudios, como los llevados a cabo por Hazzard, Celano, Gould, Lawry y Webb (1995), Kallstrom-Fuqua, Weston y Marshall (2004) y Coffey et al. (1996) en Estados Unidos, o Dufour y Nadeau (2001) en Canadá, han tratado de analizar los efectos simultáneos de las diferentes dinámicas traumatógenicas en una muestra de víctimas de abuso sexual en la infancia. No obstante, los resultados han sido

contradictorios. Hazzard et al. (1995) encontraron que únicamente la indefensión se asociaba a una medida global de malestar psicológico, mientras que Coffey et al. (1996) informaron que esta medida se relacionaba con el estigma, y Kallstrom-Fuqua et al. (2004) tanto con la indefensión como con el estigma. Además, ninguno de estos estudios ha encontrado encontró una relación significativa entre la dinámica de traición y el ajuste psicológico de las víctimas de ASI. Kallstrom-Fuqua et al. (2004), por ejemplo, no hallaron la relación esperada entre traición y problemas en las relaciones interpersonales, asociándose estos únicamente con la indefensión.

Además prácticamente ninguna de las investigaciones realizadas hasta la fecha ha contado en sus análisis con la dinámica de la sexualización traumática, al no haber incluido como variables de ajuste psicológico medidas relacionadas con el bienestar sexual. Sin embargo, tal y como algunos autores han defendido (e. g., Tsun-Yin, 1998), dicha sexualización traumática puede tener un efecto negativo sobre otros aspectos del ajuste como la autoestima, especialmente la relacionada con asociada a las relaciones interpersonales y sexuales.

OBJETIVOS DE INVESTIGACIÓN

El primer objetivo de la Tesis fue analizar la relación existente entre la experiencia de ASI y la sintomatología de TEP, en una muestra de estudiantes universitarias. Para ello se compararon en primer lugar las puntuaciones de las víctimas de ASI en TEP con las de otro grupo que no ha sufrido abuso. La primera hipótesis fue que existirían diferencias entre ambos grupos, de modo que el grupo de víctimas mostraría puntuaciones superiores en TEP.

A continuación, se analizó el papel desempeñado por las estrategias de afrontamiento para explicar la variabilidad en los niveles de TEP de las víctimas. La segunda hipótesis fue que, cuanto mayores sean las puntuaciones en afrontamiento de evitación, mayores serían las puntuaciones en TEP de las víctimas. Se esperaba también que el afrontamiento de aproximación tuviera un rol positivo en el ajuste, aunque de acuerdo con la bibliografía revisada no esta relación debería ser más débil.

Un problema intrínseco de los estudios retrospectivos que mantienen el anonimato de los participantes es el empleo de una única fuente de información para evaluar tanto el afrontamiento como el ajuste. Debido a ello, se podría plantear que los participantes con un peor ajuste psicológico, tanto víctimas como no víctimas de ASI, podrían tender a presentarse a sí mismos como mayores usuarios de estrategias de evitación más que de aproximación. Esta sería una posible explicación para las relaciones halladas en otros estudios entre el afrontamiento y el ajuste. El siguiente objetivo de nuestra tesis fue, por tanto, obtener resultados que permitieran descartar la hipótesis de un sesgo debido a la evaluación de ambas variables al mismo tiempo. Con ese fin, planteamos como tercer objetivo el comprobar dos asunciones que de cumplirse permitirían descartar la hipótesis del sesgo: los efectos de las estrategias de afrontamiento sobre el TEP deberían ser diferentes en función de las características del abuso, y también entre víctimas y no víctimas de ASI. De este modo, la esperada

tendencia de los participantes con un peor ajuste psicológico a mostrar puntuaciones superiores en afrontamiento de evitación e inferiores en aproximación difícilmente podría explicar las asunciones anteriores.

El cuarto objetivo de la tesis fue analizar los posibles efectos a largo plazo de las atribuciones de culpa por el abuso en la explicación de la variabilidad en los niveles TEP de las víctimas. La hipótesis planteada fue que aquellos participantes con mayores niveles de autoinculpación e inculpación a la familia presentarían una mayor sintomatología de TEP, mientras que la inculpación al agresor se relacionaría con una menor sintomatología.

Al igual que hicimos con las estrategias de afrontamiento, y con el fin de comprobar que los efectos de las atribuciones de culpa sobre el TEP no se deben a que los participantes con una sintomatología más grave tratan de comprender sus dificultades actuales en términos de sus respuestas al abuso, se analizaron los efectos interactivos de las atribuciones con las características del abuso. En este caso, se plantea la hipótesis de que los efectos de las atribuciones de culpa por el abuso deberían ser mayores en el caso de abusos continuados, cometidos por un familiar de la víctima y de una mayor gravedad. En este caso no comparamos los efectos de las atribuciones entre víctimas y no víctima de ASI, ya que consideramos que las atribuciones de culpa por el abuso son cualitativamente diferentes del tipo de atribuciones que se realizan en la mayor parte de los sucesos traumáticos.

El siguiente objetivo fue la formulación y puesta a prueba de un modelo para predecir la sintomatología de TEP de las víctimas de ASI considerando las características del abuso, la existencia de otros maltratos, las atribuciones de culpa y las estrategias de afrontamiento. La hipótesis planteada fue que las características del ASI indicativas de su gravedad deberían relacionarse con mayores niveles de

autoinculpación, inculpación a la familia por el abuso, y afrontamiento de evitación, así como con la gravedad de la sintomatología de TEP. A su vez, la autoinculpación e inculpación a la familia se asociarían a una mayor gravedad del TEP, tanto directa como indirectamente a través del afrontamiento por evitación, que tendría un efecto negativo sobre el TEP. Finalmente, la existencia de otros tipos de maltrato también debería relacionarse, aunque en menor medida, con los niveles de autoinculpación, inculpación a la familia, afrontamiento de evitación y sintomatología de TEP de las víctimas.

Sin embargo, a pesar de que las estrategias de afrontamiento y las atribuciones de culpa han sido las dos variables cognitivas que han recibido una mayor atención, no son las únicas que pueden tener un efecto sobre el ajuste psicológico de las víctimas de ASI. Uno de los modelos más reconocidos en el campo del ASI es el de las dinámicas traumatogénicas de Finkelhor y Browne (1985). Según estos autores, los efectos del ASI sobre el ajuste psicológico se deberían a cuatro sentimientos provocados por el abuso: la indefensión, impotencia, estigma y sexualización traumática. Nuestro séptimo objetivo fue por tanto comprobar los efectos sobre la sintomatología de TEP, a modo de ejemplo, de la existencia de otras variables también relevantes para el ajuste psicológico. La hipótesis era que unos mayores sentimientos de traición, impotencia, estigma y sexualización traumática se relacionarían con una mayor sintomatología de TEP.

Por último, tal y como se hizo en el caso de las estrategias de afrontamiento y las atribuciones de culpa, se analizaron las interacciones de los sentimientos provocados por el ASI con las características del abuso. En este caso, con el fin de comprobar si las interacciones de las variables cognitivas se producen con otras características diferentes al tipo de abuso, continuidad y relación, analizamos dos nuevas características: la edad del agresor y la existencia de revelación tras el abuso. Se espera que la relación entre los

sentimientos provocados por el ASI y el TEP sea más fuerte en el caso de abusos cometidos por un adulto y cuando hubo una revelación durante el abuso o poco tiempo después de que terminara.

Debemos señalar que, para los propósitos de esta Tesis, en todos los análisis llevados a cabo para cumplir los objetivos previos se controló la existencia de otras formas de maltrato y negligencia durante la infancia, por la influencia que estas pueden tener sobre el ajuste psicológico de la víctima (Hazen, Connelly, Roesch, Hough y Landsverk, 2009).

EXPERIMENTAL RESEARCH

STUDY 1

Coping with Child Sexual Abuse among College Students and Post-traumatic Stress Disorder: The Role of Continuity of Abuse and Relationship with the Perpetrator

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Abstract

The purpose of this study was to examine the effects of Child Sexual Abuse (CSA) on the use of coping strategies and Post-Traumatic Stress Disorder (PTSD) scores in young adults, as well as the role of avoidance and approach coping strategies in those PTSD scores in CSA victims. The role of coping strategies was studied by considering their possible interactive effect with the continuity of abuse and the relationship with the perpetrator; the effect of coping strategies on PTSD was also compared between CSA victim and non-CSA victim participants.

The sample was comprised of 138 victims of CSA and another 138 participants selected as a comparison group. Data about Child Sexual Abuse were obtained from a questionnaire developed for this purpose. Coping strategies were assessed with the How I Deal with Things Scale (Burt & Katz, 1987), while PTSD scores were assessed with the "Escala de Gravedad de Síntomas del Trastorno de Estrés Postraumático" (Severity of Symptoms of PTSD Scale; Echeburúa, Corral, Amor, Zubizarreta, & Sarasua, 1997).

Participants who had been victims of CSA showed significantly higher PTSD scores and lower approach coping strategies scores. However, differences in avoidance coping strategies between groups were not consistent and did not always follow the expected direction. Only the use of avoidance coping strategies was related to PTSD, participants who used these showing higher scores. The effects of avoidance strategies were stronger in continued than in isolated abuse, in intrafamilial than in extrafamilial abuse and in CSA victims than in non-victims.

These results confirm the idea of CSA as a high-risk experience that can affect the victim's coping strategies and lead to PTSD to a lesser or greater extent depending on the coping strategy used. Moreover, the role of these strategies varies depending on

whether or not the participant is a victim of CSA and on the characteristics of abuse (continuity and relationship with the perpetrator).

In terms of intervention, a reduction of avoidance-type strategies appears to have a beneficial effect, especially in the case of intrafamilial and/or continued CSA victims. The encouragement of “spontaneous” approach strategies (devised by the victim herself, without counseling) would probably not lead to more positive outcomes in terms of PTSD symptomatology. However, encouraging CSA survivors to engage in therapy aimed at developing effective approach strategies, as other studies have suggested, may help reduce PTSD symptoms.

Introduction

Child Sexual Abuse (CSA) is a serious social problem, due to both its high incidence and its long-term consequences. A review of the vast array of studies on the long-term effects of CSA reveals numerous psychological, social, and behavioural difficulties in adults, ranging from poor self-esteem and depression to sexual disorders and Post-Traumatic Stress Disorder (PTSD) (Briere & Elliott, 2003; Kim, Talbot, & Cicchetti, 2009; Lemieux & Byers, 2008; Levitan, Rector, Sheldon, & Goering, 2003; Roy & Janal, 2006; Spitalnick, Younge, Sales, & Diclemente, 2008). Yet, there is no evidence of any consistent set of symptoms that could be viewed as a "post-child abuse syndrome"; besides, not all survivors of childhood abuse show significant impairment in later life (Runtz & Schallow, 1997).

In fact, there is a great deal of variation among former CSA victims with regard to the type and extent of their subsequent difficulties in functioning (Merrill, Thomsen, Sinclair, Gold, & Milner, 2001). Studies that base their conclusions on the "effects" of child abuse simply on correlations between childhood experiences and symptoms measured in adulthood may be oversimplifying this apparent relationship by not taking into account other important variables that might influence later adjustment.

Recognizing that CSA experiences are not all alike, some writers have begun to examine the influences that contribute to differences in individuals' adjustment following victimization. Among these variables, it is more useful to study the processes or mechanisms to explain the development of psychological difficulties than the characteristics of abuse. Some authors have studied individual differences in the cognitive processing of the abusive experience, such as causal attributions (Feiring, Taska, & Chen, 2002), feelings of stigma (Coffey, Leitenberg, Henning, Turner, &

Bennett, 1996), and coping strategies (Spaccarelli, 1994; Wright, Crawford, & Sebastian, 2007), that seem to have an influence on recovery from CSA. The present research is focused on the positive or negative role of strategies used by victims to cope with sexual abuse experienced in their childhood.

Coping strategies

At present, several ways of measuring coping are in use, and various taxonomies of coping styles have been proposed. Comparison between studies is difficult because the labels applied to coping mechanisms in the literature are diverse. According to Lazarus (1993), coping can be analyzed in terms of its function, which can be problem-focused or emotion-focused. Problem-focused coping changes the stressful situation by acting on the environment or on oneself; emotion-focused coping attempts to change either how the situation is dealt with, or the meaning of what is happening. Active problem solving also tends to be an effective strategy across a wide range of stressful situations, while emotion-focused coping is typically less effective. However, the results of several studies with CSA victims contradict this hypothesis.

Futa, Nash, Hansen, and Garbin (2003), for example, assessed the effects of problem-focused coping (problem-focused scale), emotion-focused coping (wishful thinking, distancing, emphasizing the positive, self-blame, tension reduction, and self-isolation scales), and a mixed problem- and emotion-focused coping strategy (seeking social support scale) in a sample of female undergraduate students who had suffered some form of sexual or physical abuse during childhood. In the abused group, results showed that lower scores on social support seeking and self-isolating and higher scores

on self-blaming and wishful thinking when dealing with childhood memories predicted poorer adjustment.

Brand and Alexander (2003) have also carried out research on this model. In a sample of adult women victims of incest during childhood, they used the distinction between problem-focused and emotion-focused coping to study their influence on psychological adjustment. Emotion-focused coping subscales were disengagement, self-control, avoidance, and acceptance of responsibility. Problem-focused coping comprised planning the solution of the problem, seeking social support, and confrontation. Results showed that CSA victims who used avoidance strategies to a greater extent had higher scores on depression and psychological distress. However, seeking social support, a problem-focused strategy, was related to higher scores on depression and distress, whereas disengagement, an emotion-focused strategy, was related to lower scores on social disadjustment.

Such contradictory results have led some researchers to argue the following: as operationalized in questionnaires, emotion-focused coping includes both relatively positive behaviors, such as expressing one's feelings, and more negative behaviors that many clinicians would categorize as defensive responses, such as avoiding thinking about problems, denial, and self-medicating with alcohol or drugs (Whiffen & Macintosh, 2005). A similar alternative model is the approach-avoidance model, according to which thoughts and/or actions are directed towards or away from a threat (Merrill et al., 2001). This model emphasizes the focus of coping, rather than the function, by postulating that approach strategies are oriented towards the threat, whereas avoidance strategies are oriented away from the threat.

Many studies have found that the use of avoidance coping methods (e.g., denial, distancing, and disengagement) by CSA victims is associated with negative

psychological outcomes (Bal, Van Oost, Bourdeaudhuij, & Crombez, 2003; Cantón & Justicia, 2008; Daigneault, Hébert, & Tourigny, 2006; Filipas & Ullman, 2006; Hébert, Tremblay, Parent, Daignault, & Piché, 2006; Merrill, Guimond, & Thomsen, 2003; Rosenthal, Rasmussen, Palm, Batten, & Follette, 2005; Steel, Sanna, Hammond, Whipple, & Cross, 2004; Wright et al., 2007). Wright et al. (2007), for example, analyzed the present adjustment of 60 adult female CSA survivors through qualitative and quantitative analyses of their coping strategies. Avoidance coping was strongly associated with more depressive symptoms and poorer resolution of abuse issues.

Trauma therapy has also shown that excessive avoidance often inhibits psychological recovery. Following the self-trauma model (Briere, 2002), if the individual is sufficiently dissociated or otherwise avoidant, the intrusion-desensitization process will not include enough direct exposure to upsetting material to significantly reduce the survivor's conditioned emotional distress. At worst, this may lead the patient to directly avoid threatening material during therapy, or to drop out of treatment altogether (Briere & Scott, 2006).

However, several studies have not found such a relationship or have even found an inverse relationship, relating the use of avoidance coping to better psychological adjustment. Chaffin, Wherry, and Dykman (1997), for example, reported that all the strategies used by 84 sexually abused children to cope with their abuse (avoidant coping, internalized coping, angry coping, and active/social coping) were associated with a unique set of symptoms. Although the use of avoidant coping strategies among school-age children was found to be related to greater sexual anxieties, it was also associated with fewer behavioral problems. Internalized coping was found to be associated with increased guilt and post-traumatic stress hyperarousal symptoms. In contrast to the clinical opinion that externalizing blame and venting anger is a helpful

strategy, angry coping was found to be associated with a wide range of behavioral and emotional problems.

Approach strategies (e.g., expressing one's feelings, engaging in cognitive reframing, seeking social support) are thought to be associated with positive outcomes, as reflected in some studies (Bal et al., 2003; Merrill et al., 2001; Runtz & Schallow, 1997; Steel et al., 2004; Walsh, Blaustein, Knight, Spinazzola, & Van der Kolk, 2007). Evidence-based trauma therapy is also based on strategies that help survivors process traumatic memories (both emotional and cognitive processing), regulate negative affectivity associated with recalling such memories, and build supportive relationships (Briere & Scott, 2006). However, several studies have failed to find the expected relationship between approach coping and positive functioning in CSA victims (Filipas & Ullman, 2006; Hébert et al., 2006; Shapiro & Levendosky, 1999; Tremblay et al., 1999; Wright et al., 2007). In fact, some studies have even found an inverse relationship (Brand & Alexander, 2003; Daigneault et al., 2006).

Hébert et al. (2006), for example, in a sample of CSA victims, used an approach and an avoidance coping score in order to evaluate the relationship between coping and psychological distress. A link was found between reliance on avoidance-type coping strategies and an increase in psychological distress, measured by internalizing behavior problems, sexualized behaviors and social competence level. However, children's adaptation was not found to be significantly influenced by reliance on strategies designed to more actively confront the stressors.

Finally, Daigneault et al. (2006) even reported a relationship between the use of approach strategies and poorer psychological adjustment in a sample of female adolescents. Avoidance coping was only related to depression when all other variables

were controlled. The most frequent use of approach coping by adolescents in the study was unexpectedly associated with increased sexual concerns.

Objectives

Results of studies seem to show a stronger and more stable relationship between avoidance coping and negative consequences of CSA than between approach coping strategies and positive outcomes. Such positive outcomes seem to be less consistently related across studies. Further research is needed to understand the complex relationship between attempting to actively cope with sexual abuse and the impact of such strategies.

In the present study, the first step was to assess the relationship between the CSA experience and the scores on a measure that indicates Post-Traumatic Stress Disorder; mean PTSD scores of the victims were compared with those of another group that had not suffered abuse. The first hypothesis was that significant differences would be found between the two groups and that the victim group would show higher scores on PTSD symptomatology. The effects of CSA on the use of approach and avoidance coping strategies were also explored.

Secondly, the study dealt with the role of coping strategies in the victim's adjustment. The second hypothesis was that the higher the scores on avoidance coping, the higher the victims' PTSD scores would be. Approach strategies were expected to play a positive role; however, this relationship was not expected to be as strong, taking into account the studies reviewed.

An intrinsic problem of retrospective studies that maintain the anonymity of participants is the use of a single source of information to assess both coping and adjustment. It could be argued that people with poorer psychological adjustment, either

victims of CSA or not, might tend to present themselves as greater users of avoidance coping strategies rather than approach strategies; this is a possible explanation for the results on the effects of coping strategies on PTSD symptomatology.

To tackle this issue, the following objective of the research was to obtain results that would rule out the hypothesis of a bias due to measuring both variables at the same time. Apart from the above-mentioned study of CSA effects on the use of coping strategies, two assumptions guided the procedure used to rule out that hypothesis: the effects of coping strategies on PTSD should be different depending on the characteristics of CSA and should differ between CSA victims and non-victims. Therefore, the expected tendency of people with poorer adjustment to show higher scores on avoidance coping and lower scores on approach coping would be unlikely to explain results supporting the previous argument.

Based on these assumptions, the third and fourth hypotheses were formulated: first, the role of coping strategies on PTSD symptomatology would vary substantially when considering its possible interactive effects with the relationship with the perpetrator. Therefore, coping strategies – especially avoidance – should explain a higher proportion of variance in PTSD in intrafamilial than in extrafamilial CSA victims. The same applies to continuity of the abuse: coping effects should also vary when the role of the continuity variable (continued vs. isolated abuse) is controlled for; in other words, coping strategies used by victims of continued CSA, especially avoidance, should explain a higher proportion of variance in PTSD than that explained in isolated CSA victims.

The fourth hypothesis was that, although coping strategies may always play an important role in adjustment, they should have greater importance in the case of victims of CSA. In these cases, they should act as a moderator between CSA and PTSD

symptomatology. Therefore, the proportion of variance in PTSD explained by coping strategies, especially avoidance ones, should be higher in victims than in non-victims.

Method

Participants

A sample of 1,416 female undergraduate college students from the University of Granada (Spain) aged between 18 and 24 years (M = 19.59, SD = 1.68) participated in this study. Students who volunteered to participate completed the protocols and were given course credit for their participation. In the sample, 83.7% of participants came from intact families, 9.1% came from families with divorced parents, 4.9% had suffered the death of one or both parents, 1.3% came from a stepfamily, 0.6% came from a family with cohabiting parents, and 0.4% came from an adoptive family. Regarding parental educational level, 21.7% of fathers and 23.6% of mothers had primary studies, 24.7% and 30.2% had secondary education, 8.5% and 8.2% had vocational training, 16.4% and 14.5% had A-level equivalent, and 28.7% and 23.4% had university studies respectively.

Procedure

First, participants anonymously completed the Questionnaire on Child Sexual Abuse to identify victims of CSA. This questionnaire also provides information about the experience of sexual abuse including the following: age of onset, relationship with the perpetrator (member of the family vs. non-member, when the perpetrator is not

related), continuity of the abuse (isolated incident vs. continued abuse, for abuse involving more than one incident), and the experience of other forms of abuse and neglect during childhood. Next, CSA victims filled in the scales. The How I Deal With Things Scale (Burt & Katz, 1987) was used to assess the strategies used to cope with abuse (Self-destructive, Evasion, Nervous, Cognitive and Expressive). The "Escala de Gravedad de Síntomas del Trastorno de Estrés Postraumático" (Severity of Symptoms of PTSD Scale; Echeburúa et al., 1997) was used to assess the score on PTSD symptomatology. Non-CSA victims filled in these questionnaires in relation to another significant negative experience in their life. Participants who had been abused by different perpetrators at different times were questioned about their most traumatic experience, and asked to think about this when completing the questionnaires. Ethical approval was sought and obtained for all the materials used in this study from the Ethics Committee of the University of Granada. Confidentiality of data was secured though assigning a numeric code to each respondent. This code is the one used in the data analysis. The SPSS - Statistical Package for the Social Sciences - version 15.0 was used for all the statistical analyses.

Instruments

Questionnaire on Child Sexual Abuse

This questionnaire was developed specifically for this research. It compiles socio-demographic data and CSA experiences of participants in an anonymous way. It registers age and sex of the participant, family structure and educational level of parents**.** The questionnaire also makes it possible to assess other forms of abuse and

neglect during childhood. It includes five questions regarding physical abuse (e.g., “How often did a parent or carer slap or hit you?”), emotional abuse (e.g., “How often did a parent or carer act in a way that made you afraid of being physically hurt?”) and neglect (e.g., How often did a parent or carer ignore your need for affection?). Questions are answered on a 1 to 5 Likert scale with the categories never, once or twice, sometimes, often, or very often. Participants are defined as being physically or emotionally abused or neglected during childhood if they respond often or very often to at least one question. In the case of CSA, it gives information about the number of incidents (continuity of abuse), the age at which it happened or started in the case of continued abuse, and the relationship with the perpetrator. The definition of CSA provided to participants to identify themselves as victims is “contacts and sexual interactions between a minor and an adult or between minors if there is a 5-year age difference between them or if the child/adolescent perpetrator is in a situation of power or control over the victim, even if there is no age difference” (Hartman and Burgess, 1989). Victims of Child Sexual Abuse are asked to indicate which types of sexual activity they have suffered, ranging from those that did not involve physical contact to touching in erogenous zones, and finally oral sex and/or penetration. In the present study, CSA was defined as those cases in which abuse started before the age of 14.

How I Deal With Things Scale

This is a 29-item scale that assesses 5 dimensions of coping with sexual abuse, divided into general avoidance and approach coping scales. Avoidance subscales are: Self-destructive (“Getting yourself into risky situations more than you usually would”), Nervous/anxious (“Snapping at people for no apparent reason”) and Evasion (“Sleeping

a lot and trying not to think about what happened"). Approach subscales are: Cognitive ("Trying to rethink the situation and to see it from a different perspective") and Expressive ("Talking to family and friends about your feelings"). Each item score ranges between 1 (never) and 5 (always). For these subscales, the authors reported internal consistencies between .65 and .75 and a test-retest reliability between .68 and .83.

"Escala de Gravedad de Síntomas del Trastorno de Estrés Postraumático" (Severity of Symptoms of PTSD Scale)

This is a self-report scale that quantifies the presence and intensity of PTSD symptoms, following DSM-IV criteria (APA, 1994). The scale is comprised of 17 items, organized in a Likert format from 0 to 3, depending on the frequency and intensity of the symptoms. It gives a total PTSD symptomatology score, taking into account the symptoms of re-experiencing ("Do you have repetitive and unpleasant dreams about the incident?"), avoidance ("Do you have to make an effort to avoid activities, places or people that evoke the memory of the incident?") and arousal ("Do you have trouble sleeping?"). Authors of the scale reported an internal consistency of .84 and a test-retest reliability of .89.

Results

Child sexual abuse prevalence

Of the 1,416 participants in the study, 164 women (11.5%) reported having suffered some kind of sexual abuse before the age of fourteen. Present age mean was *M* = 19.88 (*SD* = 1.67).

Of the total number of victims of CSA, were ruled out from the study those who did not complete all the questionnaires, answered them thinking of another negative experience in spite of having been victims of CSA or failed to give the necessary information to classify them according to the continuity of abuse or the relationship with the perpetrator. Thus, the final sample was comprised of 138 victims of Child Sexual Abuse, as well as another 138 participants who were not victims, used as a comparison group. The comparison group was selected by matching the status of the family variable with that of the group of CSA victims to make both groups as similar as possible. As regards the family structure, in both groups, 79.7% of participants came from intact families, 10.1% came from families with divorced parents, 6.7% had suffered the death of one or both parents, 1.4% came from a stepfamily, 1.4% came from a family with cohabiting parents and 0.7% came from an adoptive family. Mean age was *M* = 19.80 (*SD* = 1.64) in the victim group and *M* = 19.43 (*SD* = 1.68) in the comparison group. Mean age of onset of abuse was *M* = 8.15 (*SD* = 2.65). Eighty victims (57.9%) had suffered abuse from a family member, while 73 (52.9%) had suffered continued abuse.

Traumatic events identified by the “Escala de Gravedad de Síntomas del Trastorno de Estrés Postraumático” in the comparison group can be categorized as

follows: loss of a loved one (23.9%), conflicts with parents (20.3%), peer rejection (17.4%), parental divorce and arguments between parents (16%), couple relationship problems (14.5%), and others (7.9%).

With regard to other forms of abuse and neglect during childhood, 27 (19.6%) of CSA victims and 23 (16.7%) of non-CSA participants had suffered at least one type of maltreatment.

Levels of trauma-related symptoms and coping strategies used according to the CSA history

The first step was to test the hypothesis that a history of CSA would predict higher levels of trauma-related symptoms. This was done by conducting an ANOVA including the PTSD score as dependent variable, and controlling for the experience of other types of abuse and neglect during childhood (Table 1). Results showed that participants with histories of CSA reported significantly higher levels of trauma-related symptomatology than did non-CSA participants ($F = 7.168$; $p < .01$).

Table 1
Comparisons between PTSD symptoms and coping strategies according to the CSA history ($N = 276$).

	CSA victims		Non-CSA victims		
	M	*SD*	*M*	*SD*	*F*
PTSD Score	9.19	9.81	6.42	6.60	7.168**
Self-destructive Coping	10.56	4.60	10.50	4.22	.003
Evasion Coping	17.28	5.33	14.96	4.61	15.125***
Nervous Coping	10.64	3.76	12.35	3.70	15.261***
Cognitive Coping	12.94	4.69	14.61	3.94	10.277**
Expressive Coping	17.08	5.60	19.36	4.69	13.636***

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Table 1 also shows comparisons of coping strategies between individuals with and without a history of sexual abuse, controlling again for the other forms of maltreatment. MANOVA results indicated an overall effect of CSA on coping, although results did not always follow the expected direction. Regarding avoidance strategies, CSA participants reported significantly higher levels of Evasion coping *(F* = 15.125; *p* < .001). Yet, they also reported significantly lower levels of Nervous coping (*F* = 15.261; *p* < .001). The difference between the two groups regarding Self-destructive coping was not significant (*F* = .003; *p* < ns). With regard to approach strategies, non-CSA participants reported a greater use of Cognitive (*F* = 10.277; *p* < .01) and Expressive (*F* = 13.636; *p* < .001) coping than did CSA victims.

Coping strategies used by CSA victims and PTSD

The second step was to test the hypothesis that the coping strategies used by CSA victims are associated with the trauma-related symptomatology. A multiple regression analysis was carried out for the PTSD score in the CSA victim group, using these strategies and the experience of other forms of maltreatment as predicting variables (Table 2).

Table 2
Regression analysis PTSD symptomatology according to the coping strategies and other forms of maltreatment experience in CSA victims (*N* = 138).

	Adjusted R^2	*B*	Error tip.	Beta	*t*	Sig.
	.356					.000
Other maltreatment		3.705	1.752	.150	2.115	.036
Self-destructive Coping		.828	.186	.388	4.441	.000
Evasion Coping		.553	.159	.301	3.482	.001
Nervous Coping		.332	.245	.127	1.355	.178
Cognitive Coping		-.006	.178	-.003	-.036	.972
Expressive Coping		-.299	.176	-.171	-1.698	.092

The regression model obtained for the total PTSD score, with an adjusted R^2 = .356 [F (6, 132) = 13.622, p < .000], showed that, as expected, the score on this variable was predicted by both Self-destructive (β = .388, p < .000) and Evasion coping (β = .301, p < .001). However, no association was found with Nervous coping. As for the role of approach strategies, which were expected to be less important than avoidance strategies, no relationship was found with PTSD symptoms. However, a relationship was found between the experience of other forms of maltreatment and PTSD (β = .150, p < .05).

Interaction between coping and characteristics of abuse

The third hypothesis tested was that the relationship between coping strategies and PTSD varies according to the characteristics of abuse. Two hierarchical multiple regression analyses were carried out. In the first step, the other forms of maltreatment variable (to control for this experience, victim of other forms of maltreatment *vs.* non-victim), coping strategies, and each characteristic of abuse (continuity of abuse or relationship with the perpetrator) were introduced. The second step involved introducing the interactions between coping strategies and the characteristic of CSA and checking which interactions were significant. Significant interactions are displayed in Tables 3 and 4.

Table 3
Significant tests of the moderating effect of relationship with the perpetrator on the relation between coping strategies and trauma symptoms in CSA victims (N = 138).

	Adjusted R^2 Δ	F Δ	df	Beta	t
Step 1	.353	11.678	7, 131		
Other maltreatment				.154	2.153*
Self-destructive Coping				.384	4.376***
Evasion Coping				.313	3.526***
Step 2	.020	5.011*	8, 130		
Self-destructive Coping				.374	4.314***
Evasion Coping				.313	3.584***
Relation				-.413	-2.309*
Relation*Nervous Coping				.588	2.316*

Note. Only significant results are reported

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Regarding the effects of the relationship with the perpetrator, results support the hypothesis of the interactive role of this CSA characteristic with coping strategies. An interaction was found with the Nervous/anxious strategy (β = .588, $p < .05$). As for the hypothesis about the interactive role of continuity of abuse (Table 4), an interactive effect with coping was also found. In this case, the strategy that interacted with continuity was Evasion coping (β = .845, $p < .05$).

Table 4
Significant tests of the moderating effect of continuity of abuse on the relationship between coping strategies and trauma symptoms in CSA victims (N = 138).

	Adjusted R^2 Δ	F Δ	df	Beta	t
Step 1	.365	12.265	7, 131		
Other maltreatment				.160	2.266*
Self-destructive Coping				.389	4.487***
Evasion Coping				.293	3.407***
Step 2	.025	6.220*	8, 130		
Other maltreatment				.137	1.961*
Self-destructive Coping				.391	4.600***
Continuity*Evasion Coping				.845	2.494*

Note. Only significant results are reported

* $p < .05$.

** $p < .01$.

*** $p < .001$.

In every analysis, only avoidance coping strategies (Self-destructive, Evasion and Nervous) were significant, independently or as an interaction with the characteristics of abuse. Again, no relationship was found between approach strategies and the PTSD score.

It was found once that the relationship between coping and PTSD would vary depending on both the continuity of abuse and the relationship with the perpetrator, and the difference was statistically significant. Thus, independent multiple regression analyses were carried out to determine whether this moderated relationship corresponded to the pattern expected. In other words, it was tested whether there was a stronger relationship in the case of continued abuse than in isolated abuse victims, and in intrafamilial than in extrafamilial abuse victims. Therefore, the sample was divided according to the relationship with the perpetrator (intrafamilial vs. extrafamilial) and continuity of abuse (continued vs. isolated).

Table 5
Relation between coping strategies and trauma symptoms according to the relationship with the perpetrator and continuity of abuse in CSA victims (N = 138).

CSA Characteristic		Adjusted R^2	F	df	Sig.
Relationship	Non family member	.222	3.612	6, 52	.005
	Family member	.444	11.781	6, 74	.000
Continuity	Isolated	.277	5.087	6, 60	.000
	Continued	.371	8.013	6, 66	.000

As regards the relationship with the perpetrator, the results matched the hypothesis (Table 5). Indeed, when other types of maltreatment were controlled for, the relationship between coping strategies and PTSD was stronger when the perpetrator was a member of the family (*Adjusted* R^2 = .222, p < .005 *vs. Adjusted* R^2 = .444, p < .000). Regarding the continuity of abuse, the relationship with PTSD symptomatology was also stronger when the abuse had been continued (*Adjusted* R^2 = .277, p < .000) than when it had consisted of an isolated incident (*Adjusted* R^2 = .371, p < .000).

Interaction between coping and CSA history

A hierarchical regression was used to test the hypothesis that coping strategies moderate the relationship between CSA occurrence and trauma symptomatology. Moderator relationships are indicated by the presence of a significant interaction between the proposed moderator (coping) and the independent variable (CSA). The CSA × Coping interaction was tested using a two-step hierarchical regression approach. CSA status, other forms of maltreatment status, and coping strategies were entered in the first step; the interaction terms (the products of CSA and each coping strategy) were entered in the second step. If the interaction term in the second step is significant, then a moderated relationship exists (Table 6).

Table 6
Significant tests of the moderating effect of CSA on the relationship between coping strategies and trauma symptoms in CSA victims (N = 138) and non-victims (N = 138).

	Adjusted $R^2 \Delta$	$F \Delta$	df	Beta	t
Step 1	.275	15.757	7, 269		
Other maltreatment				.115	2.171*
Self-destructive Coping				.303	4.708***
Evasion Coping				.168	2.739**
Nervous Coping				.157	2.269*
CSA				.150	2.644**
Step 2	.051	5.041**	12, 264		
Other maltreatment				.148	2.863**
CSA*Self-destructive Coping				.423	2.413*
CSA*Evasion Coping				.557	2.543**

Note. Only significant results are reported

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Ratings of coping strategies significantly moderated the relationship between CSA and the PTSD symptomatology score (Self-destructive coping: $\beta = .423$; $p < .05$; Evasion coping: $\beta = .557$; $p < .01$). Again, avoidance strategies were the only coping strategies that remained significant, independently (Self-destructive coping) or as an interaction with abuse (Evasion coping). No relationship was found between approach strategies and the trauma variable. The results also indicated that the use of these avoidance strategies was related to higher PTSD scores.

Finally, independent multiple regression analyses were carried out to test the relationships between coping strategies used and trauma symptomatology for CSA victims and non-CSA participants. The aim was to determine whether the moderated relationship conformed to the hypothesized pattern of relationship; in other words, the relationship should be stronger for CSA victims than for non-CSA participants (Table 7). In accordance with the predictions, a consistent moderator effect was found, showing a stronger relationship between coping and PTSD symptomatology for CSA

survivors than for non-CSA survivors (*Adjusted* R^2 = .203, p < .000 vs. *Adjusted* R^2 = .356, p < .000).

Table 7
Relationships between coping strategies and trauma symptoms, separate for CSA (N = 138) and non-CSA (N = 138) participants.

CSA	Adjusted R^2	F	df	Sig.	Beta	t
Non-CSA	.203	6.713	6, 132	.000		
Other maltreatment				.057	.155	1.918
Self-destructive Coping				.083	.165	1.747
Evasion Coping				.737	.028	.336
Nervous Coping				.039	.203	2.082
Cognitive Coping				.026	.192	2.248
Expressive Coping				.774	.025	.287
CSA	.356	13.622	6, 132	.000		
Other maltreatment				.036	.150	2.115
Self-destructive Coping				.000	.388	4.441
Evasion Coping				.001	.301	3.482
Nervous Coping				.178	.127	1.355
Cognitive Coping				.972	-.003	-.036
Expressive Coping				.092	-.171	-1.698

Discussion

Although primary prevention of child abuse is necessary, it is not likely to be completely eradicated. Therefore, ongoing research is needed on secondary prevention of long-term psychological sequelae subsequent to CSA (Steel et al, 2004). Previous research has focused primarily on abuse-related characteristics that are not amenable to intervention. More recent research has begun to address mediating factors which may be amenable to intervention, such as causal attributions, feelings of stigma, and coping strategies (Coffey et al., 1996; Feiring et al., 2002; Wright et al., 2007).

In this study, the prevalence of CSA (11.5% of participants) was slightly lower than in other studies carried out in Spain with university samples (Pereda & Forns,

2007) and community samples (López, 1994). This difference is probably due to the definition of Child Sexual Abuse used, as this study only included cases in which abuse started before the age of fourteen. However, other studies carried out in several countries have found a similar prevalence to that in the present study (Mujgan, Ethem, Oya, Deniz, Omer, & Ozdemir, 2006; Pereda, Guilera, Forns, & Gómez-Benito, 2009).

With regard to the first hypothesis about long-term effects of CSA, results confirm other authors' finding that victims as a group show greater difficulties in long-term adjustment than non-CSA victims, assessed in terms of Post-Traumatic Stress Disorder (Spitalnick, Younge, Sales, & Diclemente, 2008).

Statistics on the differences between groups of abuse victims and non-victims conceal the fact that, although some people with a history of CSA have numerous difficulties in adulthood, others are moderately or well adapted (Merrill et al, 2001). Therefore, the present research focused on the positive or negative influence on PTSD symptomatology of strategies used by victims to cope with sexual abuse experienced in childhood.

First of all, this study only partially supports the assumption that CSA victims are greater users of avoidance coping strategies and use approach strategies less due to their poorer psychological adjustment. Although non-CSA participants reported a greater use of approach strategies than CSA victims, the results regarding avoidance strategies are not consistent. CSA participants reported significantly higher levels of Evasion coping, but they also reported significantly lower levels of Nervous coping, and the difference between the two groups regarding Self-destructive coping was not significant.

As for the second hypothesis, data on the role of coping strategies are consistent with the vast array of previous studies (e.g., Hébert et al., 2006; Merrill et al., 2003;

Wright et al., 2007). They show that the use of Self-destructive and Evasion coping strategies leads to a greater risk of having higher PTSD scores in young adults with a history of CSA. Consistently with previous research (Grassi-Oliveira, & Stein, 2008), a relationship was also found between being a victim of physical or emotional maltreatment or neglect and PTSD. However, no relationship was found between one type of avoidance coping – Nervous-anxious coping – and PTSD symptomatology. Burt and Katz (1987), however, found a relationship between Nervous coping and psychological adjustment. Yet, this difference may be due to the type of sample used in each study. In that case, the victims were females who had recently been subjected to sexual assault.

No significant relationship was found either between approach coping strategies and victims' trauma symptomatology. Approach strategies were the only ones in which a clear difference in scores was found between both groups in the expected direction. For this reason, this would have been the only relationship supporting the hypothesis that victims' tendency to present themselves as greater users of maladaptative coping patterns (less use of approach coping and greater use of avoidance coping) explains the relationship between coping and PTSD.

Thus, as in other studies that assessed such strategies (e.g., Filipas & Ullman, 2006; Hébert et al., 2006), neither cognitive nor expressive coping were related to PTSD in CSA victims. However, other studies such as those of Runtz and Schallow (1997) or Walsh et al. (2007) found a relationship between these strategies and a better psychological adjustment; others such as those of Burt and Katz (1987) or Daigneault et al. (2006) reported an inverse relationship.

Perhaps the failure of approach coping to produce the expected improvement in functioning occurred because this coping style requires the presence of other factors to

be effectively deployed. The usefulness of tactics such as expressing feelings and making efforts to improve the situation may rest on the availability of social or material resources that would give the child greater actual or perceived control over his environment. For example, the wished-for positive impact of social support may depend on the quality and type of support received (Stevenson, Maton, & Teti, 1999). Thus, seeking support without a responsive support system being available may be associated with greater distress, whereas seeking support when it is available and when helpful responses are offered may not (Daigneault et al., 2006).

However, this does not mean that approach strategies resulting from psychotherapy are not useful. Evidence-based therapy using coping strategies that help survivors process traumatic memories, regulate negative affectivity associated with recalling such memories, and building supportive relationships has proved valuable (Briere & Scott, 2006). Thus, in spite of the lack of a positive effect of using "spontaneous" approach strategies (devised by the victim him/herself without counseling), encouragement of CSA survivors to engage in therapy to develop effective approach strategies may be useful to reduce PTSD symptomatology.

Support was found for the hypothesis that the role of avoidance strategies was not due merely to victims' tendency to present themselves as greater users of these strategies. However, it was decided to continue trying to prove the hypothesis that the effects of coping strategies on PTSD are different depending on the characteristics of CSA, and also between CSA victims and non-victims. As predicted in the third hypothesis, the role of coping strategies varied substantially when taking into account the interactive effect with continuity and relationship with the perpetrator. The relationship between coping strategies and PTSD scores was stronger when the abuse was continued and when it was committed by a member of the family. Finally, results

supported the fourth hypothesis on the greater importance of coping strategies in CSA victims than in non-victims.

Moreover, only avoidance coping strategies were found to be related to PTSD scores, independently or as an interaction with the abuse characteristics; no relationship was found between approach strategies and PTSD. The effects of coping strategies on adjustment were found to be different depending on the characteristics of CSA and between CSA victims and non-victims. Therefore, results can hardly be explained by the assumption that people with poorer adjustment score higher on avoidance coping and lower on approach coping.

It can be concluded that, in terms of intervention, the encouragement of "spontaneous" approach strategies would probably not be related to more positive outcomes in terms of PTSD symptomatology. Yet, a reduction of avoidance-type strategies would appear to have a beneficial effect, especially in intrafamilial and/or continued CSA victims. However, the lack of a positive effect of using these "spontaneous" approach strategies does not mean that encouraging CSA survivors to engage in psychotherapy where they develop effective approach strategies will not be useful in reducing PTSD symptomatology (e.g., Briere & Scott, 2006).

One of the strengths of the study is the use of measures of coping that are specific to the abuse experience. Some researchers have argued that the failure of some studies to find effects regarding approach coping (e.g., Filipas & Ullman, 2006; Hébert et al., 2006) may be due to the use of measures of coping that were not specific to the abuse experience. However, data from the present study contradict this hypothesis, since this association was not found despite using measures of coping that were specific to the abuse experience.

There are a number of limitations to the current study that must be considered. First, the study is cross-sectional and uses a single source of information to assess both the coping and PTSD scores. Longitudinal studies with some information about adjustment contributed by informants other than those who provided information about coping mechanisms could show the direction of the relationship between the different variables, as well as the stability of the measured variables (Bal et al., 2003). To overcome this limitation, we studied the interactive role of the characteristics of abuse and the participant's status (victim or non-victim).

Another limitation of the study concerns the use of retrospective reports. Although some bias has been found in these reports, it is not enough to invalidate retrospective studies on important adversities (Paivio, 2001). There is broad consensus that many victims of child abuse disclose their experiences of victimization belatedly, if at all (Hershkowitz, Horowitz, & Lamb, 2005). More than 90% of victims of sexual abuse in childhood do not report the abuse or receive public assistance (Cortés & Cantón, 2008). This means retrospective reports are the only way of finding out about these cases of CSA (Helweg-Larsen & Larsen, 2005).

Finally, the last limitation is related to the generalization of the findings, which is somewhat limited by the nature of the college sample. Some researchers have argued that college populations are composed of participants who function at a higher cognitive level than other groups (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996); therefore, college students may not be representative of CSA victims in terms of cognitive level of functioning nor of use of coping strategies (Declerck, Boone, & De Brabander, 2006). However, the selection of this type of sample has the advantage of avoiding the distortions and memory problems that older adults might have (Halperin, Bouvier, Jaffe,

Monoud, Pawlak, Laederach, et al., 1996), which is why the age of participants in the student sample was limited to 24.

STUDY 2

The Interactive Effect of Blame Attribution with Characteristics of Child Sexual Abuse on Post-traumatic Stress Disorder

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Abstract

The present study examined the role of attributions of blame for Child Sexual Abuse (CSA) in Post-traumatic Stress Disorder (PTSD) symptomatology. The interactive effects of attribution of blame with characteristics of abuse on PTSD were studied. A sample of 151 female victims of CSA participated in the study. Self blame and family blame were related to higher PTSD scores, whereas perpetrator blame was not related to PTSD. The strength of the relationship between blame and PTSD score was higher in cases of more severe, isolated and extra-familial abuse. From a clinical perspective the findings suggest that diminishing self blame and family blame attributions may be particularly advantageous, especially in the cases of isolated, extra-familial and more severe CSA.

Introduction

Victims of Child Sexual Abuse (CSA) are at a high risk of developing interpersonal and psychological problems in both the short (Feiring, Miller-Johnson, & Cleland, 2007; Tarren-Sweeney, 2008) and long term (Cantón & Justicia, 2008; Friedman, Jalowiec, McHugo, Wang, & McDonagh, 2007; Hébert, Lavoie, Vitaro, McDuff, & Tremblay, 2008; Lemieux & Byers, 2008). One of the most prevalent risks of CSA is the development of Post-traumatic Stress Disorder (PTSD; Kingston & Raghavan, 2009; Raghavan & Kingston, 2006; Spokas, Wenzel, Wiltsey Stirman, Brown, & Beck, 2009). However, previous studies have suggested that not all survivors of CSA are equally at risk and that some individuals fare well despite early adversity (Jonzon & Lindblad, 2006).

Prior research on risk factors has mostly focused on abuse-related variables such as the frequency and duration of abuse and the relationship of the victim to the perpetrator. These factors are purported to reflect the severity of abuse (e.g., Chromy, 2006; Lemieux & Byers, 2008; Ullman, 2007). Such characteristics have not, however, been found to covary consistently with life adjustment skills (Quas, Goodman, & Jones, 2003). Moreover, despite the potential of these characteristics to identify victims who might be at higher risk for adjustment problems, they are fixed and impervious to clinical intervention. Consequently, more flexible variables, such as social and cognitive factors that may be altered to improve the probability of success of CSA victims should be evaluated.

Individual differences in the cognitive processing of abuse, such as feelings of stigma (Feiring et al., 2007), coping strategies (Cantón & Justicia, 2008) and attributions of blame (Filipas & Ullman, 2006) have been studied for their influence on

recovery from CSA. The focus in the present study is the role of attributions of blame by the victim.

Attributional style refers to the propensity of an individual in making causal inferences about an event (Seligman, Abramson, Semmel, & von Baeyer, 1979). A negative attributional style leads one to ascribe the cause of negative events to one's self (internal) across situations (global) and over time (stable). It is necessary for a victim of CSA to make sense of experiences that go against her/his belief in a safe and just world. Thus, the victim must make causal attributions as to the reasons for the abuse (Feiring & Cleland, 2007).

Research on attributions following CSA has commonly focused on the direction (internal or external) of blame attribution. Barker-Collo (2001) suggested no relationship between the stability and situational dimensions of the attributional style and psychological adjustment. The direction of attribution of a traumatic event has consequences for how a victim reacts to that event. As one form of traumatic event, causal attributions are thought to moderate adjustment following CSA. Filipas & Ullman (2006) suggested that attributions of self blame may be necessary to provide some individuals with a sense of control over what has happened. Janoff-Bulman (1979) posited that some individuals may resort to self blame as a means of security that the situation is under their personal control and therefore future assaults can be avoided. Interestingly, research has shown that self blame may be helpful for certain traumas (e.g., traffic accidents) but not for others (e.g., CSA; Valle & Silovsky, 2002).

It has been demonstrated that early in childhood, negative attributional styles may be associated with psychological distress following CSA (e.g. Daigneault, Hebert, & Tourigny, 2006; Daigneault, Tourigny, & Hébert, 2006; Mannarino & Cohen, 1996; Valle & Silovsky, 2002). Clinical research has identified clear consequences for adult

victims of CSA who bring self blame attributions into adulthood (e. g., Filipas & Ullman, 2006; Steel, Sanna, Hammond, Whipple, & Cross, 2004). For example, Filipas and Ullman (2006) studied the effect of the attribution of blame at the time of abuse along with current self blame for sexual abuse experienced in childhood on PTSD scores. The authors found that only current self blame predicted PTSD symptoms. However, not every study has found a relationship between attributions in adulthood and psychological adjustment (e.g., Barker-Collo, 2001).

Measurement of attributions has been a serious and consistent limitation across studies (McMillen & Zuravin, 1997). Some researchers have categorized open-ended answers into mutually exclusive categories of blame (e.g., Perrot, Morris, Martin, & Romans, 1998). Others have employed a single-item rating of blame for CSA (e. g., Steel et al., 2004), which does not reveal the different ways people may blame themselves or others. Still others have measured several types of attribution of blame including self blame, blaming the perpetrator, blaming society and blaming someone else, but with single-item indicators (e. g., Filipas & Ullman, 2006). Each of these methods of blame attribution measurement has limitations.

From a theoretical stand point, attributions of blame for CSA can be aimed, apart from one self, at the perpetrator and other non-protective adults. The focus in research, however, has undoubtedly been aimed at self blame attributions (McMillen & Zuravin, 1997). Clinical interventions have also focused on self blame and attribution of responsibility to the perpetrator (Celano, Hazzard, Campbell, & Lang, 2002). Although some have viewed self blame and perpetrator blame as opposites (i.e. a reduction in one factor inevitably leads to an increase in the other) research suggests that they are independent factors (Feiring & Cleland, 2007). Thus, it cannot be assumed that

encouraging the victim to attribute blame to the perpetrator will reduce the odds of self blame (Celano et al., 2002).

McMillen and Zuravin (1997) studied separately the role of the attributions discussed in the conceptual and clinical literature, self blame and perpetrator blame, as well as attributions of blame to the family. Consistent with previous research, they found that self blame was related to poorer adjustment. In addition, this study was the first to report a relationship between family blame and adult adjustment. However, they found no significant relationship between perpetrator blame and life adjustment skills.

Objectives

The present study investigated the role of attributions of blame in PTSD symptomatology of adult victims of CSA. We hypothesized that higher levels of self blame and family blame would result in higher PTSD scores while higher levels of perpetrator blame would result in lower PTSD symptomatology.

An intrinsic problem of retrospective studies that maintain the anonymity of participants is the use of a single source of information to assess both attributions of blame and adjustment. It could be argued that people with poorer psychological adjustment, might present a greater tendency to self blame and family blame and are less likely to blame the perpetrator (Daigneault et al., 2006; Feiring, Taska, & Chen, 2002). It is possible that individuals who experience high levels of trauma-related symptomatology might seek to understand their current difficulties in terms of their responses to the abuse, this being a possible explanation for the result on the effects of attributions of blame on adjustment.

To tackle this issue, the objective of the research was to obtain results that would rule out the hypothesis of a bias due to measuring both variables at the same time. The assumption that guided the procedure used to rule out that hypothesis was that the effects of attributions of blame on PTSD should be different depending on the characteristics of CSA. Therefore, the expected tendency of people with poorer adjustment to show higher scores on self blame and family blame and lower scores on perpetrator blame would be unlikely to explain results supporting the previous argument.

Based on the latter assumption, the following three hypotheses were formulated. First, the role of attributions of blame on PTSD symptomatology would vary substantially when taking into account interactive effects with the continuity of the abuse. We hypothesized that the attributions of blame would account for a higher proportion of variance of PTSD scores in the case of continued abuse than an isolated case of abuse.

Second, we hypothesized that the relationship to the perpetrator would interact with attributions of blame. Thus, it was tentatively hypothesized that the attributions of blame employed by intra-familial CSA victims would explain a higher proportion of variance of PTSD score than in the case of extra-familial abuse.

Finally, we hypothesized that the type of abuse would also interact with the attributions of blame. It was hypothesized that abuse consisting of penetration/oral sex would explain a higher proportion of variance of PTSD scores than abuse consisting of touching which would in turn, explain a higher proportion of variance than exhibitionism abuse.

Method

Participants

The sample comprised 1,405 female undergraduate students (University of Granada) between the ages of 18 and 24 (M = 19.44, SD = 1.64). Students who volunteered to participate completed the protocols and received credit toward fulfilling their course requirements. Of the 1,405 participants entered in the study, 151 women (10.7%) reported having suffered some kind of sexual abuse before the age of fourteen. Thus, the final sample was comprised of 151 victims of CSA, with an average age of 19.67 years old (SD = 1.71). Of the 151 victims, 78.1% were from intact families, 9.3% from families with divorced parents, 6% had suffered the death of one or both parents, 4.6% were from a stepfamily, 0.7% were from a family with cohabiting parents and 1.3% from an adoptive family. The education levels of the fathers and mothers, respectively, were as follows: 19.7% and 20.1% completed primary school; 26.1% and 26.8% completed secondary school; 9.9% and 10.7% received professional training; 12.7% and 18.8% received A-level equivalent training; and 31.7% and 23.5%, completed university studies.

Instruments

Child sexual abuse and other maltreatments

Participants were asked to complete a retrospective self-report, specifically developed for this study to gather socio-demographic data, CSA experiences and other maltreatment experiences of participants in an anonymous way. The questionnaire also collected age and gender of the participant, family structure and educational level of parents, number of CSA incidents, type of abuse suffered (exhibitionism, touching or penetration/oral sex), relationship with the perpetrator (member of the family *vs.* non

member), continuity of abuse (an isolated incident *vs.* continued abuse), and the age at which abuse happened or started in the case of continuous abuse. The questionnaire provided participants with the following definition of CSA in order to identify themselves as victims: “contacts and sexual interactions between a minor and an adult or between minors if there is a 5 year age difference between them or if the child/adolescent perpetrator is in a situation of power or control over the victim, even if there is no age difference” (Hartman and Burgess, 1989). Participants were asked to indicate which types of sexual activity they suffered, ranging from those that did not involve physical contact, to touching in erogenous zones, and finally oral sex and/or penetration. The above information, and following the definition, was used in the decision of whether to include a participant as a CSA survivor. The questionnaire also allowed assessment of other forms of abuse and neglect during childhood. Five questions regarding physical abuse, emotional abuse and neglect (all scored on a 5 point Likert scale) were also included. Participants were defined as physically or emotionally abused or neglected during childhood if they responded “often” (4) or “very often” (5) to at least one question.

Attributions of blame

The Attributions of Responsibility and Blame Scale (McMillen & Zuravin, 1997) was used to assess attributions made about CSA. The scale is comprised of 40 items developed to tap 3 main directions of blame attribution: those implicating oneself (“I blame myself for getting into the situation where the unwanted sexual contact began”), one´s perpetrators (“I blame the person for continuing to do these things after I let it be known I wanted it to stop”) and one´s non perpetrator family members (“I blame my family for creating the situation where the sexual contact was likely to

occur"). A 5-point scale was used for respondents to indicate how strongly they agreed or disagreed with each item. The scale had a high internal consistency (Cronbach alpha coefficient = 0.92 for self-blame, 0.90 for family blame, and 0.82 for the perpetrator blame scale).

Post-traumatic Stress Disorder

PTSD symptomatology was measured by the *Escala de Gravedad de Síntomas del Trastorno de Estrés Postraumático* (Severity of Symptoms of PTSD Scale; Echeburúa, Corral, Amor, Zubizarreta, & Sarasua, 1997). This is a 17 item self-report scale that quantifies the presence and intensity of PTSD symptoms following DSM-IV criteria (APA, 1994). Items are organized in a Likert scale format from 0 to 3, according to the frequency and intensity of the symptoms. The scale gives a total score on PTSD symptomatology, resulting from the sum of the scores on the 17 items. The items take into account the re-experiencing of symptoms, n = 5 ("Do you have unpleasant and recurrent memories about the incident, including images, thoughts or perceptions?"), avoidance symptoms, n = 7 ("Do you feel unable to remember some of the relevant aspects of the incident?") and problems with arousal, n = 5 ("Do you have concentration problems?"). The scale has an internal consistency of 0.84 (Cronbach alpha coefficient).

Procedure

In a classroom setting, participants anonymously completed the questionnaires on CSA, Attributions of Responsibility and Blame and PTSD, as described above. In order to maintain anonymity of the CSA victims, non-CSA volunteers completed questionnaires in relation to a different significant negative experience. Ethical approval was sought and obtained for all materials used in this study from the Ethics Committee

of the University of Granada and informed consent was obtained from the participants. Confidentiality of data was secured though assigning a numeric code to each respondent. This code is the one used in the data analysis. The SPSS - Statistical Package for the Social Sciences - version 15.0 was used for all the statistical analyses.

Results

Descriptive data for all measures are displayed in Table 1. To test the hypothesis that attributions of blame are related to PTSD symptomatology, the partial correlations between the attributions of blame and the PTSD scores were calculated, controlling for the three characteristics of abuse and the existence of other maltreatments. In addition, the correlations between the three types of attribution were also calculated. There was a significant positive correlation between the score on the attributions of self blame (pr = .347; $p < .001$) and score on PTSD and between family blame (pr = .286; $p < .001$) and PTSD. In other words, these two attributions of blame are related to a higher risk of obtaining high scores on PTSD. However, no relationship was found between perpetrator blame and PTSD (pr = .135; $p < .095$). Correlations between the attributions of blame scales showed that self blame was positively related to the scores on family blame (pr = .211; $p < .05$). However, there was no significant relationship between perpetrator blame and self blame (pr = .017; $p < .849$) or perpetrator blame and family blame scores (pr = .143; $p < .105$).

Table 1. PTSD symptomatology, attributions of blame, characteristics of abuse and other maltreatments

Variable	Mean	*SD*	Min	Max	Variable	*N*	%
PTSD Score	11.01	11.83	0	49	Other Maltreatments	33	21.9
Self Blame Attributions	33.66	14.88	20	81	Continuity of Abuse		
					Isolated	76	50.3
					Continued	75	49.7
Perpetrator Blame Attributions	33.37	9.22	10	50	Relationship with Perpetrator		
					Non Family Member	64	42.4
					Family Member	87	57.6
Family Blame Attributions	15.30	8.02	10	45	Type of Abuse		
					Exhibitionism	34	22.5
					Touching	73	48.4
					Oral/Penetration	44	29.1

Note: Min. = minimum score, Max. = maximum score, *SD* = standard deviation

A multiple regression analysis was conducted for the PTSD score to test the relative effects and the proportion of variance explained by attributions on trauma-related symptomatology, controlling first for the three characteristics of abuse and other maltreatments variables (step 1), and introducing in a second step the attributions of blame (Table 2). The regression model obtained, with an *adjusted* $R^2 = .346$ [F (4, 147) = 11.072, $p < .000$], showed that PTSD was predicted, apart from the type of abuse ($\beta = .203$, $p < .05$) and the occurrence of other maltreatments ($\beta = .223$, $p < .01$), by both self-blame ($\beta = .298$, $p < .001$) and family blame ($\beta = .187$, $p < .05$). However, this association was not found with regard to perpetrator blame ($\beta = .083$, $p < .263$).

Table 2. Regression analysis of PTSD symptomatology according to the attributions of blame, controlling for the characteristics of the abuse and other forms of maltreatment experience in CSA victims

Variable	Adjusted R^2 Δ	*F* Δ	Error tip.	Beta	*t*	*Sig.*
Step 1	.224	10.58	13.07			.000
Other Maltreatment			2.809	.269	3.423	.001
Continuity			2.382	.097	1.205	.231
Relationship			2.395	.022	.273	.785
Type			1.701	.344	4.345	.000
Step 2	.122	9.077	11.992			.000
Other Maltreatment			2.791	.223	2.853	.005
Continuity			2.201	.057	.764	.446
Relationship			2.256	.008	.100	.921
Type			1.702	.203	2.561	.012
Self Blame			.079	.298	3.754	.000
Perpetrator Blame			.118	.083	1.124	.263
Family Blame			.144	.187	2.404	.018

Three hierarchical multiple regression analyses were performed to test the hypothesis that the relationship between attributions of blame and PTSD varies according to the three abuse characteristics, which act as moderators in that relationship. Moderator relationships are indicated by the presence of a significant interaction between the proposed moderator (CSA characteristics) and the independent variable (attributions of blame), using the total PTSD score as the dependent variable. The interaction of attributions of blame × CSA characteristics was tested using a three-step regression approach, where the three characteristics of the abuse and the occurrence of other maltreatments were entered in the first step, the three attributions in a second step, and the interaction term (the product of attributions of blame and one of the CSA

characteristics) in a third step. Significant interactions are shown in Tables 3 (interaction with continuity), 4 (relationship) and 5 (type of abuse).

When the interaction of continuity of abuse with attributions of blame was added as a predictor, thirty-eight percent of the total variance in PTSD was accounted for (Table 3). The results support an interactive role of this CSA characteristic (continuity) with attributions, as seen through an interaction with the self blame score (β = -.189, p < .01). We also found single effects of self blame (β = .323, p < .001), type of abuse (β = .222, p < .01) and the existence of other maltreatments (β = .219, p < .01).

Table 3. Significance tests of the moderating effect of the continuity of the abuse on the relation between attributions of blame and trauma symptoms in CSA victims

Variable	Adjusted R^2 Δ	F Δ	Error tip.	Beta	t
Step 1	.224	10.58	13.070		
Other Maltreatment			2.809	.269	3.423 ***
Type			1.701	.344	4.345 ***
Step 2	.122	9.077 ***	11.992		
Other Maltreatment			2.791	.223	2.853 **
Type			1.702	.203	2.561 *
Self Blame			.079	.298	3.754 ***
Family Blame			.144	.187	2.404 *
Step 3	.031	3.028 *	11.713		
Other Maltreatment			2.727	.219	2.880 **
Type			1.680	.222	2.841 **
Self Blame			.078	.323	4.134 ***
Continuity * Self Blame			.144	-.189	-2.652 **

* p < .05; ** p < .01; *** p < .001. *Note:* Only significant results are reported

An interactive effect of the relationship with the perpetrator and attributions of blame was also found (Table 4). In this case, self blame (β = -.228, p < .01) had a

significant interaction with the relationship variable. Again, there was a significant effect of self blame (β = .308, p < .001), as well as the type of abuse (β = .207, p < .01) and other maltreatments (β = .226, p < .01) on the PTSD score.

Table 4. Significance tests of the moderating effect of relationship with the perpetrator on the relation between attributions of blame and trauma symptoms in CSA victims

Variable	Adjusted $R^2 \Delta$	$F \Delta$	Error tip.	Beta	t
Step 1	.224	10.58	13.070		
Other Maltreatment			2.809	.269	3.423 ***
Type			1.701	.344	4.345 ***
Step 2	.122	9.077 ***	11.992		
Other Maltreatment			2.791	.223	2.853 **
Type			1.702	.203	2.561 *
Self Blame			.079	.298	3.754 ***
Family Blame			.144	.187	2.404 *
Step 3	.038	3.533 *	11.646		
Other Maltreatment			2.749	.226	2.940 **
Type			1.659	.207	2.675**
Self Blame			.078	.308	3.933 ***
Relationship * Self Blame			.144	-.228	-3.183**

* p < 0.05; ** p < 0.01; *** p < 0.001. *Note:* Only significant results are reported

Finally, regarding the effects of type of abuse suffered by the victim, there was a significant effect of the variable resulting from the interaction of this characteristic of the abuse and family blame (β = .187, p < .01) (Table 5). This variable, together with the type of abuse (β = .229, p < .01), self blame (β = .353, p < .001) and other maltreatments (β = .218, p < .01) explained 39% of the variance on PTSD scores.

Table 5. Significance tests of the moderating effect of the type of abuse on the relation between attributions of blame and trauma symptoms in CSA victims

Variable	Adjusted R^2 Δ	F Δ	Error tip.	Beta	t
Step 1	.224	10.58	13.070		
Other Maltreatment			2.809	.269	3.423 ***
Type			1.701	.344	4.345 ***
Step 2	.122	9.077 ***	11.992		
Other Maltreatment			2.791	.223	2.853 **
Type			1.702	.203	2.561 *
Self Blame			.079	.298	3.754 ***
Family Blame			.144	.187	2.404 *
Step 3	.040	3.670 *	11.628		
Other Maltreatment			2.718	.218	2.869 **
Type			1.682	.229	2.928 **
Self Blame			.084	.353	4.210 ***
Type * Family Blame			.187	.187	2.556 **

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$. *Note:* Only significant results are reported

With the knowledge that the relationship between the attributions of blame and the PTSD score would vary depending on the characteristics of the abuse, and that the difference was statistically significant, we carried out independent multiple regression analyses in order to determine whether the moderated relationship conformed to the pattern of relationship hypothesized. The three attributions scores, the characteristics of abuse and the occurrence of other maltreatments were introduced as predicting variables. To this end, the sample was divided according to the continuity of abuse (continued *vs.* isolated), the relationship with perpetrator (intra-familial *vs.* extra-familial) and type of abuse (exhibitionism, touching, penetration/oral sex).

In the case of continuity of abuse (Table 6), the relation between attributions and PTSD score was stronger when the abuse consisted of an isolated incident than when it had been continuous (Adjusted R^2 = .464, p < .000 *vs.* Adjusted R^2 = .259, p < .001). The relationship with PTSD score was also stronger in the case of extra-familial abuse (Adjusted R^2 = .463, p < .000) than when the perpetrator had been a member of the family (Adjusted R^2 = .346, p < .000). Finally, with regard to the type of abuse suffered by the victim, there was no significant relationship found in the case of abuse consisting of exhibitionism (Adjusted R^2 = .114, p < .746). There was a significant relationship in the case of both touching and penetration/oral sex with PTSD score, with a stronger relationship found in the penetration/oral sex cases (Adjusted R^2 = .305, p < .006 *vs.* Adjusted R^2 = .336, p < .0001 touching vs. penetration/oral sex, respectively).

Table 6. Association between attributions of blame and PTSD according to the relationship with the perpetrator, continuity of the abuse and type of abuse

CSA Characteristic	Category	*Adjusted* R^2	*Error tip.*	*F*	*p*
Continuity	Isolated	.464	10.008	10.802	.000
	Continued	.259	13.413	4.724	.001
Relationship	Non Family Member	.463	10.951	9.206	.000
	Family Member	.346	11.925	7.616	.000
Type	Exhibitionism	.114	9.360	.575	.746
	Touching	.305	13.494	3.844	.006
	Oral/Penetration	.326	11.078	6.038	.000

Discussion

Clinicians increasingly use empirically based cognitive-behavioral techniques in the treatment of CSA victims. Attribution retraining is often a primary component of

this work (Celano et al., 2002). The present research was focused on the role of the attributions of blame in young adult CSA victims on PTSD symptomatology. The present data are consistent with the vast array of previous studies (e. g., Filipas & Ullman, 2006; Steel et al., 2004), suggesting that the level of self blame attribution predicted subsequent symptomatology of PTSD after controlling for characteristics of abuse and occurrence of other maltreatments.

The results are consistent with McMillem and Zuravin´s (1997) study, finding a relationship between high scores on family blame and a higher risk of PTSD symptoms. However, although McMillem and Zuravin (1997) found that family blame had an impact on anxiety scores and the probability of maltreating their own children, they also found no relationship between family blame and self-esteem. Moreover, our results agree with Finkelhor and Browne's (1985) description of the betrayal of trust that occurs when someone on whom a child relies maltreats them, or as may be the case, fails to protect them. It is therefore understandable and expected that children would experience greater psychological distress in correlation with the perception that their family did not protect them or failed to support them after finding out about the abuse. However, in spite of the importance of this kind of blame attribution, clinical practice has focused mainly on the shift from self blame to perpetrator blame (Celano et al., 2002).

Our results showed that blaming the abuser was not related to a lower PTSD severity. This result contradicts the clinical literature that has emphasized perpetrator blame over blame of family members (Celano et al., 2002). However in spite of this emphasis in the literature, other studies (e. g., Feiring & Cleland,2007; McMillem & Zuravin, 1997) have also failed to find a relationship between perpetrator blame and the psychological adjustment of the victim.

In addition to the attributions of blame, one characteristic of the abuse, the type of acts committed influenced PTSD symptomatology. This result has been obtained by a number of researchers (e.g., Filipas & Ullman, 2006; Lemieux & Byers, 2008). A relationship between PTSD scores and the other two studied characteristics of abuse: continuity of the abuse and relationship with perpetrator was not found. Whereas some authors have found a relationship between these variables and the psychological well-being of the victim (e.g., Ullman, 2007), others have failed in demonstrating that link (e.g., Quas et al. 2003).

Overall, these results suggest that while self blame and family blame attributions are maladaptive, perpetrator blame attributions do not necessarily have a positive effect on adjustment. Moreover, it may be suggested that perpetrator blame should not be encouraged in detriment of a reduction on self-blame attributions. As no significant correlation was found in the present and other studies, it cannot be assumed that encouraging young people to make perpetrator blame attributions will diminish the probability that they will make blame attributions towards themselves (Celano et al., 2002; Feiring & Cleland, 2007).

The interaction of attributions of blame and the characteristics of abuse has not previously been studied. Our hypothesis that the effects of attribution of blame on PTSD scores would depend on the CSA characteristics was confirmed. The relationship between attributions of blame and PTSD score was found to be stronger in more severe cases of abuse vs. less severe cases. As predicted, there was also an interaction between attributions of blame and the continuity of abuse. However, our results showed that the effect of attribution of blame on PTSD scores was greater when there was an isolated case of abuse as opposed to continued abuse, contradicting our original hypothesis. In addition, contrary to our original prediction, the interactive effect of the relationship

with the perpetrator and the attribution of blame on PTSD symptomatology was greater when abuse was committed by a non family member. It may be proposed that factors (e.g., coping strategies) other than attribution of blame may have had a more important role in the recovery of CSA victims in the continued abuse and intra-familial abuse categories. In any case, the findings of the present study cannot be simply explained by individual adjustment traits. In other words, it was not the case that the less stable participants scored higher on self blame and family blame attributions. The effect, in fact was interactive.

Although this research contributes to the literature by defining those aspects of causal attributions of blame in CSA victims that have an influence on later psychological adjustment, it also has a number of limitations that must be considered. First of all, it is a cross-sectional study, employing a unique source of information in order to assess both attribution and PTSD. A solution to this limitation was sought by studying the interactive role of abuse characteristics, and the findings of the study can hardly be explained by the hypothesis of a bias due to the measurement of both variables simultaneously.

Another limitation of the study concerns the use of retrospective reports. However, previous reports have shown that the small amount of bias present in retrospective reports is not strong enough to invalidate research on major adversities (Hardt & Rutter, 2004). As Bifulco, Moran, Baines, Bunn and Stanford (2002) note, there are certain merits to undertaking a retrospective study. First, there are fewer ethical issues in studying abuse that occurred a number of years prior to the study. Second, and with cautious measurement to minimize bias, the long-term consequences can be assessed along with characteristics of the abuse (Helweg-Larsen & Larsen,

2005). Lastly, many victims of CSA disclose tardily, if at all, more than 90% of victims of CSA neither reporting it (Cortés & Cantón, 2008).

The final possible limitation of our study is the use of a college sample. Some researchers have argued that the prevalence of abuse is lower in college populations than in other groups (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996). However, both the present study and other previous research have shown that the number of college age victims is not lower than that seen in community samples (Pereda, Guilera, Forns, & Gómez-Benito, 2009).

In conclusion, and regardless of these limitations, the present study found a number of areas for therapeutic treatment that can be pursued with CSA victims. Diminishing self blame as well as family blame attributions seems particularly advantageous, especially in the case of isolated, extra-familial and more severe CSA. However, encouraging perpetrator blame attributions does not seem to have a positive effect on the PTSD symptomatology reduction.

ESTUDIO 3

Un Modelo de los Efectos del Abuso Sexual Infantil sobre el Estrés Post-traumático: El Rol Mediador de las Atribuciones de Culpa y Estrategias de Afrontamiento

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Resumen

Mediante modelos de ecuaciones estructurales se analizan los efectos directos e indirectos de la gravedad del ASI, las atribuciones de culpa por el abuso, y las estrategias de afrontamiento sobre la sintomatología del Trastorno de Estrés Post-traumático (TEP). Se controlaron además los efectos de otros maltratos sufridos durante la infancia. La muestra la componían 163 estudiantes universitarias víctimas de Abuso Sexual Infantil (ASI). Los resultados obtenidos sugieren que las víctimas de abusos más graves presentan niveles superiores de autoinculpación, inculpación a la familia y empleo de estrategias de evitación. El haber sufrido otro tipo de maltrato se encontraba también relacionado con niveles superiores de inculpación a la familia. Por último, las dos atribuciones de culpa se encontraban indirectamente relacionadas con el TEP a través del afrontamiento de evitación. Las fuertes relaciones halladas entre las atribuciones de culpa, estrategias de afrontamiento y TEP sugieren que sería útil la intervención temprana con víctimas de ASI en un esfuerzo por modificar las atribuciones que realizan acerca del abuso y el modo en que lo afrontan.

Abstract

Employing structural equation modeling, the direct and indirect effects of the severity of CSA, attributions of blame for the abuse and coping strategies on the Post-traumatic Stress Disorder (PTSD) symptomatology are analyzed. The effects of other types of child maltreatment on PTSD were also controlled. The sample was comprised of 163 female college students who were victims of Child Sexual Abuse (CSA). The results suggested that victims of more severe abuse showed higher levels of avoidant coping, self blame and family blame. Having suffered other kinds of abuse or neglect was also related to higher family blame attributions. Finally, the two attributions of blame scales were indirectly related to PTSD symptomatology through avoidant coping. The strong relationships between attributions of blame, coping strategies and PTSD suggest that it might be useful to intervene early with children who have suffered CSA in an effort to modify the attributions they make about the abuse and the way they cope with it.

Introducción

En las tres últimas décadas, los estudios han sugerido de forma consistente que el Abuso Sexual Infantil (ASI) se asocia a consecuencias psicológicas negativas en poblaciones adultas, variando desde la depresión y los problemas de autoestima hasta los trastornos sexuales y de la personalidad (Cantón y Justicia, 2008; Del Campo y López, 2006; Lemieux y Byers, 2008). Una de sus consecuencias más frecuente es el Trastorno de Estrés Post-traumático (TEP), habiendo informado muchos estudios que las víctimas de ASI presentan un mayor riesgo de desarrollar síntomas de TEP durante la edad adulta (e. g., Kingston y Raghavan, 2009).

Sin embargo, existe una gran variabilidad respecto al ajuste psicológico de las víctimas de ASI, de forma que no todas ellas presentan problemas a largo plazo (Rind, Tromovich y Bauserman, 1998). Es fundamental, por tanto, determinar qué variables explican las diferencias en el ajuste de las víctimas. Desde esta perspectiva, se han estudiado tanto características del abuso como factores cognitivos tales como las estrategias de afrontamiento o las atribuciones de culpa (Lemieux y Byers, 2008; Feiring y Cleland, 2007; Wright, Crawford y Sebastian, 2007).

Características del ASI

El impacto del ASI en la víctima se puede explicar, al menos en parte, por las características del abuso. En este sentido, los estudios han encontrado que aquellos abusos relacionados de forma más consistente con un peor ajuste psicológico son aquellos que han sido más frecuentes (Chromy, 2006; Hébert, Tremblay, Parent, Daignault y Piché, 2006), en los que se han cometido actos más intrusivos (Lemieux y

Byers, 2008), y cuando había una relación de proximidad entre el agresor y la víctima (McLean y Gallop, 2003).

Sin embargo, algunos estudios han encontrado resultados inconsistentes respecto a la relación entre estas variables y el ajuste de las víctimas, sugiriendo que los factores cognitivos podrían ser más importantes que las características del ASI a la hora de predecir dicho ajuste (e. g., Paolucci, Genuis y Violato, 2001; Quas, Goodman y Jones, 2003). Además, puesto que no es posible intervenir sobre estas características, su utilidad desde un punto de vista clínico resulta muy limitada. Debido a ello, el estudio de los procesos que explican el desarrollo de una determinada sintomatología resula de un mayor interés para el diseño de intervenciones eficaces.

Estrategias de afrontamiento

Como un mecanismo cognitivo susceptible de cambio, las estrategias de afrontamiento han sido estudiadas por su rol en el ajuste de las víctimas tras el abuso. El modelo predominante para clasificar las estrategias empleadas para afrontar el abuso es el de *aproximación-evitación*. Según este modelo, los pensamiento y/o acciones se pueden dirigir hacia una amenaza (aproximación) o a alejarse de ella (evitación) (Merrill, Thomsen, Sinclair, Gold y Milner, 2001).

La mayoría de los estudios que han examinado el efecto de diferentes estrategias han encontrado una relación entre las estrategias de evitación y un peor ajuste psicológico tras el ASI (e. g., Cantón y Justicia, 2008; Filipas y Ullman, 2006; Hébert, et al., 2006; Wright et al., 2007). Sin embargo la relación entre las estrategias de aproximación y el ajuste psicológico ha sido mucho menos consistente, habiendo concluido la mayoría de los estudios que estas estrategias no influyen en el bienestar de

las víctimas (e. g., Brand y Alexander, 2003; Cantón y Justicia, 2008; Hébert et al., 2006; Wright et al., 2007).

Atribuciones de culpa

Otro factor cognitivo que ha sido estudiado como un posible mediador entre el ASI y el ajuste psicológico han sido las atribuciones de culpa por el abuso. Desde un punto de vista teórico, la víctima puede dirigir la responsabilidad del abuso hacia sí misma, hacia el agresor y hacia otros adultos. El énfasis de la investigación, sin embargo, ha estado en las atribuciones de autoinculpación (McMillen y Zuravin, 1997). Los resultados de los estudios indican que este tipo de atribuciones se asocian a un peor ajuste psicológico (e. g., Filipas y Ullman, 2006; Steel, Sanna, Hammond, Whipple y Cross, 2004). La inculpación a la familia también se ha asociado a un peor ajuste (McMillem y Zuravin, 1997). Sin embargo, la mayoría de los estudios no han encontrado una relación entre la inculpación al agresor y el bienestar psicológico de las víctimas (e. g., Feiring y Cleland, 2007; McMillem y Zuravin, 1997).

Los efectos del ASI sobre las estrategias de afrontamiento y atribuciones de culpa

Ante los efectos negativos de las estrategias de evitación y las atribuciones de culpa, los estudios han tratado de identificar quién podría estar en mayor riesgo de emplearlas. La bibliografía clínica sugiere que los abusos sexuales más graves dan lugar a una mayor autoinculpación (e. g., Feiring y Cleland, 2007). Actos más intrusivos, cometidos por una persona cercana, y de forma más persistente podrían llevar al niño a pensar que merece el abuso por alguna característica personal (Quas et al., 2003). Respecto a los predictores del afrontamiento por evitación, autores como Filipas y Ullman (2006) han encontrado que las víctimas de abusos de mayor gravedad

(implicando penetración, cometidos por una figura paterna y de mayor duración), informan de un mayor uso de estrategias de evitación que aquellas que han sufrido abusos menos graves.

La interacción entre afrontamiento y atribuciones de culpa

Además de incrementar los síntomas provocados por el ASI, las atribuciones de culpa también podrían estar asociadas a un estilo de afrontamiento de evitación (Street, Gibson y Holohan, 2005). Las víctimas que piensan que son culpables de su experiencia podrían tener mayores dificultades para aceptar el abuso, aumentando así el riesgo de que utilicen estrategias como la negación o el distanciamiento para evitar los sentimientos de culpa persistentes (Najdowski y Ullman, 2009). Por tanto, las estrategias utilizadas podrían mediar la relación entre las atribuciones y la recuperación tras el abuso. Sin embargo, y a pesar de que la bibliografía al respecto ha sido muy numerosa en referencia a víctimas de violencia doméstica y violación (e. g., Najdowski y Ullman, 2009; Street et al., 2005), los estudios sobre las interacciones entre afrontamiento y atribuciones de culpa en víctimas de ASI han sido muy escasos.

Objetivos

Mientras que numerosos estudios han examinado las relaciones individuales entre las características del ASI, las atribuciones de culpa, estrategias de afrontamiento, y sintomatología de TEP, ninguno ha tratado de explicar empíricamente las interrelaciones de estas variables en una muestra con un historial de ASI, ni ha controlado los efectos de la existencia de otras formas de abuso o negligencia durante la infancia.

Este estudio emplea modelos de ecuaciones estructurales para analizar los efectos directos e indirectos de las características del ASI, las atribuciones de autoinculpación e inculpación a la familia y el uso de estrategias de evitación sobre los niveles de TEP en una muestra de mujeres víctimas de ASI, controlando los efectos de otros tipos de maltrato. Para los propósitos del estudio, únicamente la evitación, autoinculpación e inculpación a la familia fueron seleccionados como posibles mediadores, puesto que se han encontrado de forma consistente que las estrategias de afrontamiento por aproximación y la inculpación al agresor tienen poco o ningún efecto sobre la recuperación de las víctimas (Feiring y Cleland, 2007; Hébert et al., 2006; Wright et al., 2007).

Basándonos en la literatura previa, la hipótesis planteada fue que las características del ASI que reflejan su gravedad se encontrarían asociadas con mayores niveles de autoinculpación, inculpación a la familia por el abuso, y afrontamiento de evitación, así como con la gravedad de la sintomatología de TEP. La autoinculpación e inculpación a la familia, por su parte, se asociarían a una mayor gravedad del TEP, tanto directa como indirectamente a través del afrontamiento por evitación, que tendria un efecto negativo sobre el TEP. Por último, la existencia de otros maltratos se relacionaría con los niveles de autoinculpación, inculpación a la familia, afrontamiento de evitación y sintomatología de TEP de las víctimas.

Método

Participantes

La muestra del estudio estuvo compuesta por 1529 estudiantes universitarias, de entre 18 y 24 años (M = 19.43, DT = 1.63). Del total de participantes en el estudio, 163 mujeres (10.7%) informaron haber sufrido algún tipo de abuso sexual antes de los 14

años. Por lo tanto, la muestra final estuvo formada por 163 víctimas de ASI, con una edad media de 19.69 (*DT* = 1.70). En cuanto a nivel educativo familiar, un 19.5% de los padres y un 21.7% de las madres tenían estudios primarios; un 26% y un 25.5% el graduado escolar; el 10.4% y el 11.2% formación profesional; bachiller el 12.3% y el 18%; y estudios universitarios el 31.8% y el 23.6%, respectivamente.

Instrumentos

Cuestionario sobre Abuso Sexual Infantil. Este cuestionario recoge la información socio-demográfica y experiencias de ASI de forma anónima. Registra la edad del participante, el nivel educativo de los padres y una serie de aspectos relacionados con el ASI y sus características: número de incidentes, tipo de actos sufridos, relación con el agresor y edad a la que ocurrió. El cuestionario proporciona a las participantes la siguiente definición de ASI: *contactos e interacciones sexuales entre un menor de edad y un adulto o entre menores de edad si existe una diferencia de cinco años entre ellos o si el niño/adolescente agresor se encuentra en una posición de poder o control sobre la víctima, aunque no haya diferencia de edad*. Se pide a las participantes que señalen el tipo de actividades sexuales que habían sufrido y que iban desde las que no implicaban contacto físico, a los tocamientos y, finalmente, al sexo oral y/o penetración. La información previa, y siguiendo la definición de ASI, se emplea para tomar la decisión de considerar o no a un participante como víctima de ASI.

Este cuestionario también permite evaluar la existencia de otros tipos de abuso y negligencia durante la infancia. Incluye cinco preguntas relativas al abuso físico, emocional y negligencia. Estas preguntas se responden a través de una escala tipo Likert con categorías de respuesta entre 1 y 5. Son considerados como víctimas de maltrato o

negligencia aquellos participantes que han respondido frecuentemente (4) o muy frecuentemente (5) en al menos un ítem.

The Attributions of Responsibility and Blame Scale (McMillen y Zuravin, 1997). Evalúa las atribuciones que las víctimas hacen acerca del ASI. Para los propósitos de este estudio, se seleccionaron 30 ítems para cubrir dos direcciones de las atribuciones de culpa: autoinculpación (e. g., *Me siento mal por no haber peleado o protestado más*), e inculpación a la familia (e. g., *Culpo a mi familia por no haber hecho más para protegerme*). Se emplea una escala de cinco puntos para que los participantes indiquen en qué grado están de acuerdo con cada ítem. Respecto a la consistencia interna, se obtuvieron coeficientes alfa de Cronbach de .92 para la autoinculpación y .89 para la inculpación a la familia.

How I Deal With Things Scale (Burt y Katz, 1987). Evalúa las estrategias empleadas para hacer frente al ASI. Únicamente se incluyeron 12 de los ítems originales, eliminando aquellos correspondientes a las estrategias de afrontamiento por aproximación. La escala evalúa dos dimensiones del afrontamiento por evitación: autodestructivo (e. g., *Beber mucho alcohol o tomar otras drogas más de lo usual*), y evasión (e. g., *Tratar de ignorar todos los pensamientos y sentimientos sobre el abuso*). La puntuación de cada ítem oscila entre 1 (nunca) y 5 (siempre). La consistencia interna (alfa de Cronbach) del afrontamiento autodestructivo fue de .74 y la de evasión de .73.

Escala de Gravedad de Síntomas del Trastorno de Estrés Postraumático (Echeburúa, Corral, Amor, Zubizarreta y Sarasua, 1997). Se trata de una escala de 17 ítems que evalúa la presencia e intensidad de los síntomas del TEP, siguiendo los criterios de DSM-IV (APA, 1994). Los ítems se encuentran organizados en un formato tipo Likert (0 a 3), de acuerdo a la frecuencia e intensidad de los síntomas. La escala evalúa la presencia de síntomas de reexperimentación (e. g., *¿Tiene recuerdos desagradables y*

recurrentes del suceso, incluyendo imágenes, pensamientos o percepciones?), evitación (e. g., *¿Se siente incapaz de recordar alguno de los aspectos importantes del suceso?*), e hiperactivación (e. g., *¿Tiene dificultades de concentración?*). Los valores alfa de Cronbach fueron de .84, .79 y .84 respectivamente.

Procedimiento

Después de la aprobación del proyecto por parte del Comité ético de la Universidad de Granada, se obtuvo el consentimiento informado de los participantes. La participación fue voluntaria, y se permitió a las participantes abandonar el estudio en cualquier momento. La confidencialidad de los datos se garantizó a través de la asignación de un código numérico a cada cuestionario.

En primer lugar, las participantes completaron el *Cuestionario sobre Abuso Sexual Infantil*, que permitió la identificación de las víctimas de ASI y la obtención de información sobre las características del abuso: continuidad (abuso incidental *vs.* continuado), relación con el agresor (intrafamiliar *vs.* extrafamiliar) y tipo de abuso (exhibicionismo, tocamientos o sexo oral/penetración). A continuación las participantes completaron las escalas para evaluar las atribuciones que hacen acerca del abuso (autoinculpación e inculpación a la familia), las estrategias de evitación utilizadas para afrontar el abuso (autodestructivo y evasión), y los síntomas de reexperimentación, evitación e hiperactivación. Con el objetivo de mantener la confidencialidad, los participantes que no habían sufrido ASI respondieron a todos estos cuestionarios en relación a alguna otra experiencia negativa significativa. El análisis de los datos se basó en modelos de ecuaciones estructurales, y se llevó a cabo con AMOS 16.0.

Resultados

La tabla 1 muestra los estadísticos descriptivos para todas las variables del estudio. Dado que el TEP está parcialmente caracterizado por los síntomas de evitación, en primer lugar examinamos las correlaciones entre el afrontamiento de evasión y los diferentes grupos de síntomas de TEP para evaluar la posible presencia de un solapamiento predictor-criterio. La correlación más alta fue la existente entre el afrontamiento de evasión y los síntomas de hiperactivación (r =.39), seguida de las correlaciones con los síntomas de evitación (r =.36) y reexperimentación (r =.30). Además, se repitieron todos los análisis del estudio prediciendo el TEP sin los síntomas de evitación, y encontramos el mismo patrón de resultados. Estos hallazgos sugieren que el afrontamiento de evasión, al menos tal y como es medido en este estudio, no evalúa el mismo constructo que los síntomas de evitación del TEP.

Tabla 1. Estadísticos descriptivos de todas las variables del estudio

Variable	*M*	*DT*	Min.	Max.	Variable	*N*	%
Síntomas de Reexperimentación	2.81	3.14	0	14			
					Continuidad del abuso		
Síntomas de					Aislado	80	49.1
Evitación	3.05	4.13	0	14	Continuado	83	50.9
Síntomas de					Relación de parentesco con		
Hiperactivación	3.08	3.90	0	15	el agresor		
					No miembro	67	41.1
Afrontamiento					Miembro de la familia	96	58.9
Autodestructivo	10.54	4.70	6	28			
					Tipo de abuso		
Afrontamiento de					Exhibicionismo	30	18.4
Evasión	16.97	4.91	6	28	Tocamientos	93	57.1
					Oral/Penetración	40	24.5
Autoinculpación	35.76	14.71	20	81	Víctima de otros maltratos	33	20.2
Inculpación a la familia	14.95	7.98	4	45			

En primer lugar se llevó a cabo una matriz de correlaciones para comprobar el patrón de relaciones e identificar las que eran excesivas (r > .90; Kline, 1998), indicando redundancia. Tal y como se muestra en la tabla 2, las correlaciones entre las variables de TEP eran las más fuertes, pero la redundancia no parece ser un problema. Las correlaciones dentro de cada factor fueron casi siempre más altas que las existentes entre diferentes factores. El patrón de correlaciones fue el esperado, encontrándose una relación global entre características del abuso, atribuciones de culpa, estrategias de afrontamiento y síntomas de TEP.

Modelo 1: Modelo inicial

Para los propósitos del estudio las tres características del abuso (tipo, continuidad y relación), se combinaron en la variable latente gravedad del abuso, haciendo lo mismo con las estrategias de afrontamiento autodestructiva y de evasión (afrontamiento de evitación), y con los síntomas de reexperimentación, evitación e hiperactivación (sintomatología de TEP). El proceso de análisis se inició con un modelo que incluía todas las relaciones directas e indirectas entre la gravedad del ASI y el TEP a través de las atribuciones de culpa y afrontamiento de evitación. Se controló la existencia de otros maltratos incluyendo las relaciones entre esa variable y cada mediador (autoinculpación, inculpación a la familia y afrontamiento de evitación), así como el TEP.

Tabla 2. Correlaciones entre todas las variables de estudio

Variable	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. Tipo de abuso	1										
2. Continuidad	.377***	1									
3. Relación	.209*	.236**	1								
4. Otros maltratos	.078	.122	.097	1							
5. Autoinculpación	.442***	.233**	.037	.091	1						
6. Inculpación familia	.157	.190*	.093	.393***	.204*	1					
7. Autodestructivo	.330***	.142	.050	.215*	.435***	.254**	1				
8. Evasión	.231*	.118	.058	.002	.352***	.127	.357***	1			
9. Reexperimentación	.274**	.246**	.062	.200*	.377***	.351***	.456***	.303***	1		
10. Evitación	.291***	.248**	.016	.179*	.438***	.363***	.550***	.365***	.800***	1	
11. Hiperactivación	.283**	.222*	.111	.144	.359***	.308***	.481***	.387***	.704***	.796***	1

Nota. * $p < .05$; ** $p < .01$; *** $p <. 001$

Este modelo sugiere que una mayor gravedad del abuso se relaciona con puntuaciones superiores en autoinculpación (β = .55; p < .001) e inculpación a la familia (β = .19; p < .05); la autoinculpación e inculpación a la familia se relacionan con un mayor uso de estrategias de evitación (β = .51; p < .001) (β = .23; p < .05), y las estrategias de evitación se asocian a puntuaciones superiores en sintomatología de TEP (β = .73; p < .01). Se encontró también una relación entre la existencia de otros maltratos y la inculpación a la familia (β = .36; p < .001). Sin embargo, el resto de posibles relaciones no fueron significativas: gravedad del abuso y afrontamiento de evitación y TEP; autoinculpación e inculpación a la familia y TEP; y otros maltratos con autoinculpación, afrontamiento de evitación, y TEP. Los índices de ajuste del modelo, con χ^2 (gl = 21) = 38.099, p < .371, fueron los siguientes: el RMSEA fue .020, el CFI .995, y el TLI .991, estando dentro de los límites recomendados de .050 y .90 (Kline, 1998). El modelo obtenido predecía el 54% de la varianza en sintomatología de TEP.

Modelo 2: Modelo final

El siguiente objetivo fue obtener el modelo más sencillo que se ajustara mejor a los datos. A través de un proceso iterativo, AMOS permite fijar de forma secuencial los valores de las relaciones no significativas en 0 y examinar las consecuencias en el ajuste del modelo. Basándonos en el Browne-Cudeck Criterion (BCC), el resultado de este proceso confirmó que el mejor modelo (BCC0 = .000) era aquel en el que se deberían eliminar la relaciones de la existencia de otros maltratos con la autoinculpación, afrontamiento de evitación y TEP. Las relaciones entre la gravedad del abuso y el TEP, y entre la autoinculpación e inculpación a la familia también deberían eliminarse, siendo

la relación entre la gravedad del abuso y el afrontamiento de evitación la única de las relaciones no significativas que debía mantenerse.

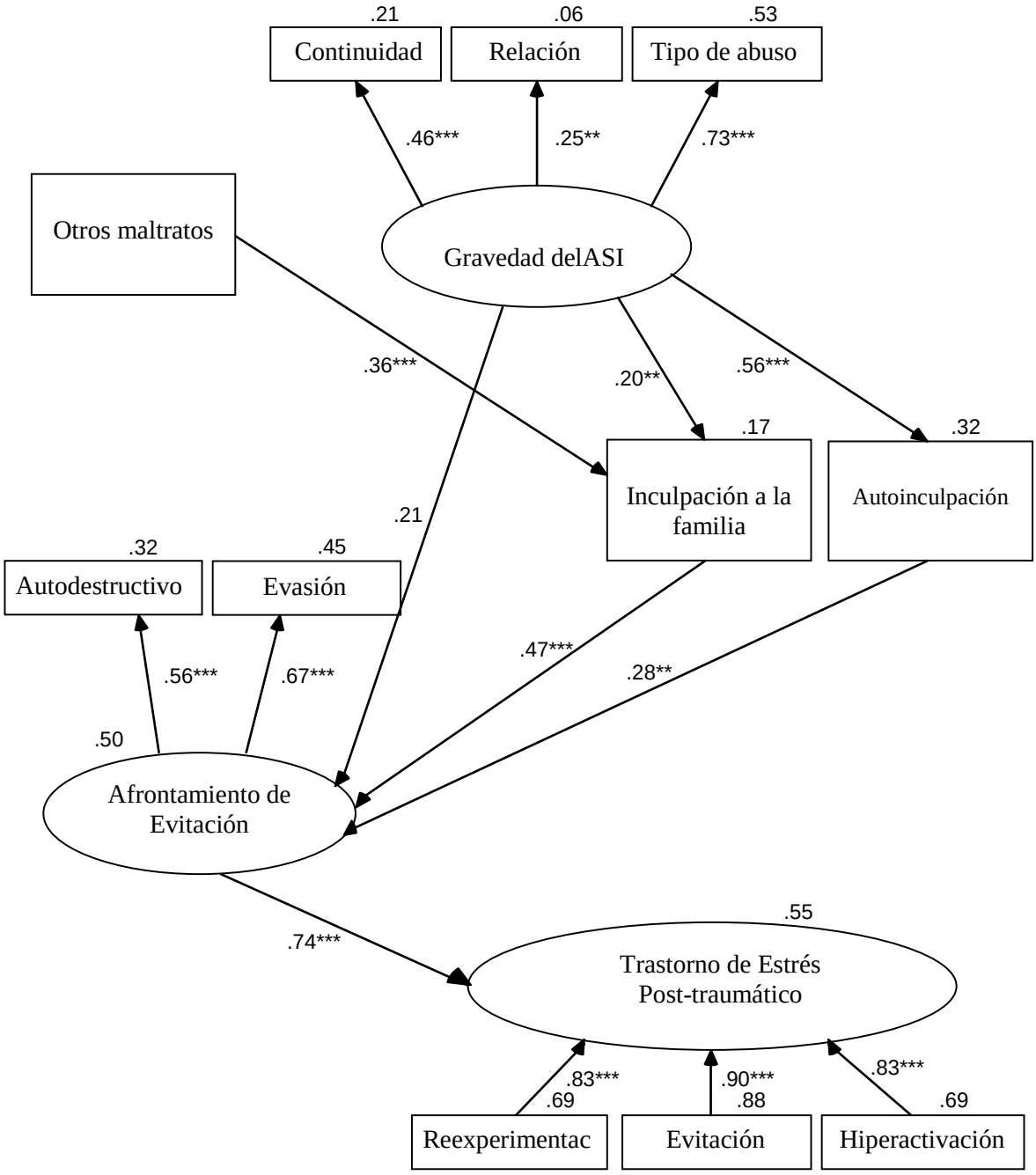
Antes de eliminar esas relaciones consideramos las implicaciones teóricas. A pesar de que los estudios sobre el ASI sugieren que las características del ASI pueden tener una influencia sobre la sintomatología de TEP, esta relación puede estar completamente mediatizada por las atribuciones y estrategias de afrontamiento. Por otra parte, como se ha sugerido especialmente por la literatura sobre víctimas de agresión sexual, los efectos de las atribuciones de culpa podrían estar totalmente mediatizados por las estrategias empleadas por la víctima. Por tanto, únicamente se mantuvo la relación entre la gravedad del abuso y las estrategias de evitación. El resto de relaciones no significativas se eliminaron del modelo y éste fue calculado de nuevo.

El modelo final se presenta en la figura 1. Por lo que respecta a los índices de ajuste del modelo [χ^2 (gl = 40) = 42.361, p < .369], el CFI y el TLI permanecieron en .995 y .991 respectivamente, mientras que el valor del RMSA mejoró ligeramente hasta .019, con un intervalo de confianza del 90% de .000 a .059. La tabla 3 muestra los efectos de las variables predictoras sobre el TEP en este modelo final. La eliminación de las relaciones no significativas no provocó una reducción de la fuerza de las restantes relaciones del modelo. El modelo final predecía un 55% de la varianza en sintomatología de TEP de las víctimas de ASI.

Tabla 3. Efectos no estandarizados y estandarizados de la gravedad del abuso, experiencia de otros maltratos, atribuciones de culpa, y afrontamiento de evitación sobre el TEP (Modelo final).

	Efectos no estandarizados			Efectos estandarizados		
	Ef. indirectos	Ef. directos	Ef. totales	Ef. indirectos	Ef. directos	Ef. totales
Gravedad del abuso	2.286		2.286	.392		.392
Otros maltratos	.485		.485	.075		.075
Autoinculpación	.061		.061	.345		.345
Inculpación familia	.068		.068	.206		.206
Afrontamiento evitación		.710	.710		.744	.744

Figura 1. Modelo predictivo de la sintomatología de TEP entre las víctimas de ASI. Los rectángulos representan variables observadas, los óvalos variables latentes. Los valores presentados son coeficientes estandarizados.



Discusión y conclusiones

El presente estudio analiza, en una muestra de víctimas de ASI, las relaciones entre la gravedad del abuso, atribuciones de culpa, estrategias de afrontamiento, existencia de otros maltratos y TEP. Los resultados obtenidos sugieren que la gravedad del abuso, evaluada en términos de continuidad, relación con el agresor y tipo de actos cometidos, incrementa las atribuciones de autoinculpación e inculpación a la familia por el abuso. Esto sugiere que las víctimas que han sufrido abusos consistentes en tocamientos y especialmente penetración, y las víctimas de abusos continuados son especialmente vulnerables a verse a si mismas y a sus familias como culpables del abuso. Sin embargo, el hecho de que el agresor fuera un miembro de la familia se relacionaba más débilmente con esas atribuciones. Estos resultados son consistentes con los obtenidos por Feiring y Cleland (2007), quienes encontraron que la gravedad del abuso se relacionaba con puntuaciones más altas en autoinculpación e inculpación a la familia por el abuso. Filipas y Ullman (2006) también encontraron que actos sexuales más graves y una mayor frecuencia y duración del abuso se asociaba a una mayor autoinculpación. Además, estos autores no encontraron una asociación entre la relación con el agresor y la autoinculpación.

Asimismo, los resultados del estudio indican que la existencia de otras formas de abuso y/o negligencia predecían las atribuciones de culpa a la familia, pero no la autoinculpación. También señalan que la gravedad del abuso y la existencia de otras formas de maltrato sólo explicaban una pequeña proporción de la varianza de las atribuciones de culpa. Por consiguiente, deben existir otras variables que afecten al estilo atribucional, incluidas otras características del abuso y también otras experiencias vitales.

Los análisis indicaron que las atribuciones de culpa se relacionaban con un mayor uso de estrategias de evitación. Este hallazgo es consistente con otros estudios llevados a cabo con víctimas de agresión sexual (e. g., Najdowski y Ullman, 2009). Al estar acompañada de unos sentimientos negativos de autoinculpación e inculpación a la familia, es probable que la experiencia de ASI resulte más estresante, llevando quizás a una confianza en estrategias de evitación como un medio para escapar de pensamientos y sentimientos dolorosos (Street et al., 2005). Los resultados también señalaron un efecto directo de la gravedad del abuso sobre el uso posterior de las estrategias de evitación. Este resultado es consistente con otros estudios que han informado de una relación directa entre las características del ASI y la forma en que la víctima lo afronta (e. g., Merril et al., 2001). Por último, se encontró un efecto directo de las estrategias de afrontamiento de evitación sobre las puntuaciones en TEP. Estas estrategias pueden provocar mayores síntomas de malestar psicológico, ya que podrían bloquear o interferir con el procesamiento emocional o cognitivo de las experiencias traumáticas. Este resultado es consistente con numerosos estudios que han examinado los efectos del afrontamiento de evitación sobre el ajuste psicológico de las víctimas de ASI (e. g., Cantón y Justicia, 2008; Hébert et al., 2006; Wright et al., 2007).

Sin embargo, y contrariamente a nuestra hipótesis, no se encontró un efecto directo de la gravedad del abuso sobre las puntuaciones en TEP de las víctimas. A pesar de que algunos estudios han informado de una relación entre las características del ASI y el ajuste psicológico (e. g., Lemieux y Byers, 2008; Ullman, 2007), otros muchos han obtenido resultados inconsistentes (e. g., Paolucci et al., 2001; Quas et al., 2003). Esto sugiere que los factores cognitivos pueden ser más importantes que las características del abuso para predecir el ajuste de las víctimas de ASI. Tampoco se encontró un efecto directo de las atribuciones de culpa sobre las puntuaciones en TEP. Muchos de los

estudios sí han hallado este efecto de la autoinculpación e inculpación a la familia sobre el ajuste tras el ASI (e. g., Quas et al., 2003). Sin embargo, en el presente estudio las atribuciones de culpa sólo se relacionaban indirectamente con el TEP a través de las estrategias de afrontamiento, una asociación que no había sido puesta a prueba en los estudios previos.

Finalmente, las relaciones de la existencia de otros maltratos con la autoinculpación, afrontamiento de evitación y TEP no fueron significativas, y se eliminaron del modelo. Por lo tanto, el maltrato o negligencia se relacionaban con el TEP únicamente a través de la inculpación a la familia. Chelfa y Ellis (2002) también analizaron la relación entre la experiencia de maltrato y las estrategias empleadas para hacer frente al ASI, encontrando que el haber sufrido abuso físico por parte de los padres no se relacionaba con dichas estrategias.

Este estudio presenta algunas limitaciones que deben ser señaladas. En primer lugar, algunos autores han llamado la atención sobre los problemas para generalizar los resultados obtenidos con muestras universitarias. Sin embargo, al estudiar los efectos a largo plazo del ASI, el empleo de este tipo de muestras nos permite evitar las distorsiones y problemas de memoria que los adultos de mayor edad podrían presentar (Halperin, Bouvier, Jaffe, Monoud, Pawlak, Laederach et al., 1996).

Otra limitación podría ser el empleo de informes retrospectivos. Sin embargo, a pesar de que se han hallado ciertos sesgos en estos estudios, no son los suficientemente grandes como para invalidar la investigación retrospectiva sobre experiencias traumáticas (Hardt y Rutter, 2004). Además, tal y como concluyeron Cantón y Cortés (2008), más del 90% de las víctimas de ASI no denuncian el abuso ni reciben apoyo institucional, por lo que los informes retrospectivos constituyen el único medio de estudiar estos casos. Por último, el diseño correlacional impide hacer interpretaciones

causales. Los presentes hallazgos deberían ser replicados mediante diseños longitunidales, que permitirían examinar la fuerza y las direcciones de las relaciones causales y comparar las consecuencias sobre el ajuste a través del tiempo (Calvete, Estévez y Corral, 2007; Moreno, Morante, Rodríguez y Rodríguez, 2008).

En conclusión, a pesar de las limitaciones señaladas, el presente estudio enfatiza la importancia de las atribuciones de culpa y del afrontamiento como factores mediadores en el impacto del ASI. Estos factores podrían ser útiles para la indentificación de aquellas víctimas de ASI con un mayor riesgo de desarrollar TEP (mujeres con un historial de ASI más grave, que llevan a cabo atribuciones de autoinculpación e inculpación a la familia, y que tienden a usar un estilo de afrontamiento de evitación), así como en la práctica clínica. Las fuertes relaciones entre atribuciones de culpa, estrategias de afrontamiento y TEP sugieren que podría ser útil el intervenir de forma temprana con niños que han sufrido ASI, con objeto de modificar sus atribuciones del abuso y el modo en que lo afrontan. De este modo, una reducción en los sentimientos de autoinculpación y en la inculpación a la familia, así como en el uso de estrategias de evitación, repercutiría en una disminución de la sintomatología de TEP.

STUDY 4

The Effects of Perpetrator Age and Abuse Disclosure on the Relationship Between Feelings Provoked by Child Sexual Abuse and Post-traumatic Stress

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Abstract

The present study examined the role of feelings provoked by Child Sexual Abuse (CSA) in Post-traumatic Stress Disorder (PTSD) symptomatology in a sample of 163 female survivors of CSA. Finkelhor and Browne's traumagenic dynamics model (1984) was applied. The interactive effects of provoked feelings with perpetrator age and the existence of abuse disclosure were also studied. Results showed an overall effect of feelings provoked by CSA on PTSD. In addition, the strength of these relationships was greater when abuse was committed by an adult perpetrator and when a disclosure was made during the time of abuse, or a short time after the abuse had occurred.

Introduction

The psychological and physical impact of Child Sexual Abuse (CSA) has received a great deal of attention in the last 20 years (Sapp & Vandeven, 2005). Research on CSA can be characterized in terms of various generations of research topics (Merrill, Thomsen, Sinclair, Gold, & Milner, 2001). In the first generation of CSA research, investigators attempted to catalog the short- and long-term effects that may result from CSA experiences. Studies have consistently found that female survivors of CSA both in clinical and non-clinical samples, experience a myriad of social and psychological difficulties, including interpersonal, sexual and emotional disorders (e. g., Goodkind, Ng, & Sarri, 2006; Lemieux & Byers, 2008; Pazzani, 2007; Peter, 2008; Tarren-Sweeney, 2008). Specifically, one of the most prevalent issues suffered by female survivors of CSA, is the development of symptoms of Post-traumatic Stress Disorder (PTSD; Choi, Klein, Shin, & Lee, 2009; Kingston & Raghavan, 2009). However, the first generation of research found a great deal of variation among CSA survivors specifically in regard to the type and extent of subsequent difficulties in functioning. In addition, not all survivors suffer significant impairment later in life (Jonzon & Lindblad, 2006).

The second generation of research built on the variability found in the first generation and endeavored to identify variables that moderate the relationship between CSA and its negative outcomes. Some studies have found that individual differences in psychological adjustment post-CSA depend on variables related to the abuse suffered. These variables include the relationship with the perpetrator, the type of acts committed and the frequency of abuse (e.g., Ullman, 2007; Lemieux & Byers, 2008). However, other studies have found inconsistent results regarding the relationship between these

variables and adjustment (e. g., Quas, Goodman, & Jones, 2003), suggesting that social, environmental and cognitive factors may be more important than the characteristics of the abuse when predicting the adjustment of survivors of CSA. Thus, individual differences in the cognitive processing of the abuse, such as coping strategies (Cantón & Justicia, 2008), attachment (Aspelmeier, Elliott, & Smith, 2007) and feelings provoked by the abuse (Feiring, Simon, & Cleland, 2009), have been investigated for their potential influence on recovery from CSA.

The use of theoretical models to identify mediator variables has been scarce (e. g., DiLillo, 2001; Rumstein-McKean & Hunsley, 2001). Models such as Spaccarelli´s model (Spaccarelli, 1994), Post-traumatic Stress Disorder (Wolfe, Gentile, & Wolfe, 1989), or traumagenic dynamics (Finkelhor & Browne, 1985), have attempted to explain the effects of CSA on the victim. However, it has been noted (e. g., Merril et al., 2001), that few studies have attempted to test these models in practice. The aim of the present study was to put one of the most recognized models, the traumagenic dynamics model (Finkelhor & Browne, 1985), into effect.

Finkelhor and Browne (1985) suggested a conceptual framework to examine the traumatic impact of CSA on survivors. According to their traumagenic dynamics model, the experience of sexual abuse can be analyzed in terms of four trauma-causing factors: powerlessness, betrayal, stigmatization and traumatic sexualization. These four traumagenic dynamics, when present, alter the survivor's cognitive and emotional orientation to the world, and create trauma by distorting self-concept, world-view, and affective capacities.

Powerlessness refers to the process in which the child's will, desire, and sense of efficacy are continually contravened. Betrayal refers to the discovery that someone on whom the victim is vitally dependent has caused them harm. The survivor may

experience betrayal not only at the hand of the offender, but also by family members who were unable or unwilling to protect or believe them or who have a changed attitude toward the victim after the disclosure of the abuse. Stigmatization refers to the negative connotations, for example, badness, shame, and guilt that are communicated to the child about the abuse and that then become incorporated into the child's self-image. Finally, traumatic sexualization refers to a process by which a child's sexuality (sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of the sexual abuse. Finkelhor and Browne' s (1985) model suggests that these dynamics shape the way the survivor interacts with the world, possibly accounting for the psychological and interpersonal problems that are characteristic of CSA survivors.

Although Finkelhor and Browne (1985) described these traumagenic dynamics in their effects during childhood (near the time of abuse), internalized thoughts and feelings regarding the abuse may still play a role in adjustment long into adulthood. These perceptions may be internalized during childhood and retained into adulthood or they may change during development. In either case, the extent to which these four perceptions are experienced during adulthood may also account for differing levels of psychological adjustment in women who experienced CSA (Dufour & Nadeau, 2001).

The importance and impact of the traumagenic model have lead researchers in an attempt to develop instruments and therapy to assess the impact of sexual abuse on CSA survivors based on the four dynamics (e. g., Celano, Hazzard, Webb, & McCall, 1996; Finkelhor & Browne, 1985; Kallstrom-Fuqua, Weston, & Marshall, 2004; Pearce & Pezzot-Pearce, 1997). However, these prior investigations have centered exclusively on one isolated dynamic (e. g., Feiring & Cleland, 2007; Feiring et al., 2009; Kim, Talbot, & Cicchetti, 2009). Kim et al. (2009) for example, found that feelings of shame

in adult women survivors of CSA predicted the level of conflicts with intimate partners and with family members. Feiring et al. (2009) found that a feeling of stigma predicted sexual difficulties and dating aggression in a sample of child and adolescent victims of CSA.

To date, few studies (e.g., Hazzard, Celano, Gould, Lawry, & Webb, 1995; Kallstrom-Fuqua et al.,2004 and Coffey, Leitenberg, Henning, Turner, & Bennet,1996 in the United States, and Dufour & Nadeau, 2001 in Canada) have attempted to analyze the simultaneous effects of the different traumagenic dynamics in women survivors of CSA. However, results of these studies have been contradictory. For example, Hazzard et al. (1995) found that psychological distress was only related to powerlessness, while Coffey et al. (1996) found this measure was related to stigmatization, and Kallstrom-Fuqua et al. (2004) found an effect of both powerlessness and stigmatization on psychological distress. Moreover, none of these studies have found a relationship between the betrayal dynamic and the psychological adjustment of CSA survivors. For example, while Kallstrom-Fuqua et al. (2004) found an effect of powerlessness on interpersonal difficulties, they found no effect of betrayal in their sample of community women.

The least studied dynamic is sexualization, as no psychological adjustment variables related to sexual well-being have been investigated. However, some authors have proposed (e. g., Tsun-Yin, 1998) that traumatic sexualization can have a negative impact on other aspects of psychological adjustment. Moreover, although research on maltreatments other than CSA has been extensive (e. g., Gibb, Schofield, & Coles, 2009; Richmond, Elliott, Pierce, Aspelmeier, & Alexander, 2009), to date, there have been no studies assessing and controlling simultaneously for effects of other forms of maltreatment and traumagenic dynamics on psychological adjustment.

Further research is needed to understand the complex relationship between the traumagenic dynamics provoked by abuse and the psychological adjustment of female CSA survivors. In the present study, the role of the four traumagenic dynamics on PTSD symptomatology of a group of female CSA survivors was assessed, controlling for the effects of the characteristics of abuse and the existence of other maltreatments. In addition, the age of the perpetrator and the disclosure of the abuse are two other variables that have been shown to impact the psychological adjustment of the survivor (Kogan, 2005; Smith & Cook, 2008; Sperry & Gilbert, 2005; Ullman, 2007). Those who suffered an abuse by an adult *vs.* a peer (a minor), and those who did not disclosed the abuse experienced worse psychological adjustment. However, little is known about the interactive effect of these variables with traumagenic dynamics. We hypothesized that the traumagenic dynamics would interact with the age of the perpetrator and the nature of abuse disclosure. Specifically, we expected that the effects of traumagenic dynamics would be stronger in the case of abuse committed by an older perpetrator than in the case committed by a minor. In addition, we expected that the effects of traumagenic dynamics would be stronger when abuse was concealed, than when a disclosure was made.

Methods

Participants

A sample of 1,529 female undergraduate college students from the University of Granada, aged 18 to 24 years (M = 19.43, SD = 1.63) participated in the study. Students

who volunteered to participate completed the protocol and were given course credit for their participation. Of the 1,529 participants entered in the study, 163 women (10.7%) reported having suffered some kind of sexual abuse before the age of fourteen. Thus, the final sample was comprised of 163 survivors of CSA, with an average age of 19.69 years (*SD* = 1.70).

Of the 163 survivors, 77.9% were from intact families, 9.8% from families with divorced parents, 6.1% had suffered the death of one or both parents, 4.3% were from a stepfamily, 0.6% from a family with cohabiting parents and 1.2% from an adoptive family. The education levels of the fathers and mothers, respectively, were as follows: 19.5% and 20.7% completed primary school; 26% and 25.5% completed secondary school; 10.4% and 11.2% received professional training; 12.3% and 18% received A-level equivalent training; and 31.8% and 23.6%, completed university studies.

Procedure

Participants anonymously completed the *Questionnaire on Child Sexual Abuse* (developed specifically for this research, see below for description) in order to obtain information about experience of sexual abuse including the following: age of onset, type of abuse (exhibitionism, touching or oral sex/penetration), relationship with the perpetrator (member of the family *vs.* non-member, when the perpetrator is not related), continuity of the abuse (isolated incident vs. continued abuse, for abuse involving more than one incident), the age of the perpetrator (minor (younger than 18 years) *vs.* adult (18 years or older)), the existence or not of a disclosure when the abuse was taking place or short time after it had finished and the experience of other forms of abuse and neglect during childhood. The participants then completed 2 scales. The *Children's*

Impact of Traumatic Events Scale-Revised (CITES-R; Version modified by Hazzard et al., 1995) was used to assess feelings provoked by abuse (stigma, betrayal, powerlessness and traumatic sexualization). The *Escala de Gravedad de Síntomas del Trastorno de Estrés Postraumático* (Severity of Symptoms of PTSD Scale; Echeburúa, Corral, Amor, Zubizarreta, & Sarasua, 1997) was used to assess the score of PTSD symptomatology. In order to ensure the anonymity of the participants, those who did not experience CSA completed both questionnaires in relation to another significant negative experience in their life. Ethical approval was obtained from the Ethics Committee of the University of Granada for all materials used in this study. Confidentiality of data was secured through assigning a numeric code to each respondent. The SPSS - Statistical Package for Social Sciences - version 15.0 was used for all statistical analyses.

Instruments

Questionnaire on Child Sexual Abuse

The Questionnaire on Child Sexual Abuse, developed specifically for this research, anonymously compiled socio-demographic data and CSA experiences of participants. It collected age of the participant, family structure and educational level of parents**.** In the case of CSA, it gathered information about the number of incidents, the age at which abuse occurred or started in the case of continued abuse, the relationship with the perpetrator, the age of the perpetrator and the existence or non existence of disclosure about the abuse, during the abuse was taking place or short time after it had finished. The definition of CSA provided to participants was as follows: *"contacts and sexual interactions between a minor and an adult or between minors if there is a 5-year*

age difference between them or if the child/adolescent perpetrator is in a situation of power or control over the victim, even if there is no age difference" (Hartman & Burgess, 1989). Participants were asked to indicate which types of sexual activity they had suffered, ranging from those that did not involve physical contact to touching in erogenous zones, and finally oral sex and/or penetration. The above information, following the definition, was used in the inclusion or exclusion of a participant as a CSA survivor. For the present study, CSA was defined as those cases in which abuse started before the age of 14. Through this questionnaire we were also able to assess other forms of abuse and neglect during childhood through five questions regarding physical abuse (e. g., *"How often did a parent or caregiver slap or hit you?"*), emotional abuse (e. g., *"How often did a parent or caregiver act in a way that made you afraid of being physically hurt?"*) and neglect (e. g., *"How often did a parent or caregiver ignore your need for affection?"*). Questions were answered on a 1 ("never") to 5 ("very often") Likert scale with the options between 1 and 5 as "once or twice", "sometimes", and "often". Participants were identified as suffering childhood physical or emotional abuse or neglected if they respond "often" or "very often" to at least one question.

Children's Impact of Traumatic Events Scale-Revised (CITES-R; Version modified by Hazzard et al., 1995)

The CITES-R assesses the feelings provoked by CSA on the survivor, following Finkelhor and Browne´s (1985) model of traumagenic dynamics. The scale included 56 items divided into 4 subscales: stigma (e. g., *"Abuse happened because I wasn't clever enough to stop it"*), betrayal (e. g., *"People usually take advantage of others"*), powerlessness (e. g., *"It does not matter what I do, I cannot avoid bad things*

to happen"), and traumatic sexualization (e. g., *"It is difficult to distinguish between affection and sexual contact"*). A 4-point scale was used for respondents to indicate how strongly they agreed or disagreed with each item (0 = "Totally false", 4 = "Totally true"). The internal consistency obtained in the present study was Cronbach alpha = 0.85 for stigma 0.75 for betrayal, 0.73 for powerlessness, and 0.87 for traumatic sexualization.

Escala de Gravedad de Síntomas del Trastorno de Estrés Postraumático (Severity of Symptoms of PTSD scale; Echeburúa et al., 1997)

The Severity of Symptoms of PTSD Scale is a 17-item self-reported scale that quantifies the presence and intensity of PTSD symptoms, following DSM-IV criteria (APA, 1994). Items are organized in a Likert scale format from 0 to 3, according to the frequency and intensity of the symptoms. The scale gives a total score of PTSD symptomatology, resulting from the sum of the scores on all items. The items take into account avoidance symptoms, n = 7 (e. g., *"Do you feel unable to remember some of the relevant aspects of the incident?"*), the re-experiencing of symptoms, n = 5 (e. g., *"Do you have unpleasant and recurrent memories about the incident, including images, thoughts or perceptions?"*), and problems with psychological arousal, n = 5 (e. g., *"Do you have concentration problems?"*). The scale has an internal consistency of 0.84 (Cronbach alpha coefficient).

Results

Descriptive statistics of all measures are presented in Table 1. To test the hypothesis that traumagenic dynamics would predict the PTSD symtptomatology of

CSA survivors, the partial correlations between the four dynamics and the PTSD scores were calculated, controlling for the characteristics of abuse and the existence of other maltreatments. There was a significant positive correlation between PTSD scores and stigma (pr = .380; p < .001), betrayal (pr = .383; p < .001), powerlessness (pr = .367; p < .001) and traumatic sexualization (pr = .337; p < .001).

Table 1.
PTSD symptomatology, feelings provoked by abuse, characteristics of abuse and other maltreatments (N = 163)

Variable	Mean	*SD*	Min	Max	Variable	*N*	%
PTSD Score	9.84	10.14	0	39	Other Maltreatments	35	25.5
					Continuity of Abuse		
Stigma	37.81	15.92	8	88	Isolated	80	49.1
					Continued	83	50.9
					Relationship with Perpetrator		
Betrayal	16.03	7.15	1	51	Non Family Member	67	41.1
					Family Member	96	58.9
					Type of abuse		
					Exhibitionism	30	18.4
Powerlessness	13.95	6.26	1	31	Touching	93	57.1
					Oral/Penetration	40	24.5
					Perpetrator age		
Traumatic sexualization	4.35	5.45	0	19	< 18	82	50.3
					> 18	81	49.7
					Disclosure		
					Non disclosure	108	66.7
					Disclosure	54	33.3

Note: Min. = minimum score, Max. = maximum score, *SD* = standard deviation

A multiple regression analysis (Table 2) was conducted for the PTSD score to test the relative effects and the proportion of variance explained by traumagenic dynamics on trauma-related symptomatology, controlling for the characteristics of the abuse and the existence of other maltreatments. The other maltreatment variable, along with the type of abuse, relationship with the perpetrator, continuity of abuse, age of the perpetrator and existence of disclosure were introduced in a first step, while the stigma, betrayal, powerlessness and traumatic sexualization were introduced in the second step.

After introducing the characteristics of the abuse and the existence of other maltreatments (step 1), two variables; the type (β = .241, p < .01) and the continuity of abuse (β = .178, p < .05) predicted 13% of the variance of the PTSD scores. After introducing the four traumagenic dynamic variables (step 2), the regression final model, with an *adjusted* R^2 = .329, showed that three dynamics; stigma (β = .185, p < .05), betrayal (β = .178, p < .05) and powerlessness (β = .230, p < .05) were related to PTSD scores. However, there was no significant relationship between the traumatic sexualization (β = .154, p = .067) score and PTSD symptomatology of victims, nor was there a significant relationship between any of the characteristics of the abuse or maltreatments and PTSD symptomatology.

Table 2.
Regression analysis of PTSD symptomatology according to the feelings provoked by abuse, controlling for the characteristics of the abuse and other forms of maltreatment in CSA survivors

Variable	Adjusted R^2	*F Δ*	*Error tip.*	Beta	*t*	*Sig.*
Step 1	.126	3.870	9.534			.000
Other Maltreatment			2.177	.145	1.637	.094
Type			1.445	.241	2.747	.007
Continuity			1.819	.178	1.979	.049
Relationship			1.844	-.016	-.173	.863
Perpetrator age			1.823	.052	.576	.566
Disclosure			1.907	-.021	-.237	.813
Step 2	.329	10.908***	8.307			.000
Other Maltreatment			1.925	.069	.888	.377
Type			1.353	.147	1.798	.075
Continuity			1.618	.101	1.268	.207
Relationship			1.623	-.031	-.387	.699
Perpetrator age			1.610	.081	1.017	.311
Disclosure			1.676	.008	.107	.915
Stigma			.060	.185	1.969	.045
Betrayal			.120	.178	2.101	.038
Powerlessness			.132	.230	2.405	.019
Traumatic sexual.			.190	.154	1.848	.067

Two hierarchical multiple regression analyses (Table 3 and Table 4) were performed to test the hypothesis that the relationship between traumagenic dynamics and PTSD varies according to the age of the perpetrator and the existence of disclosure acting as moderators in the relationship. Moderator relationships are indicated by the presence of a significant interaction between the proposed moderator (age of perpetrator and disclosure) and the independent variable (traumagenic dynamics), using the PTSD

score as the dependent variable. The interactions of traumagenic dynamics × age of perpetrator and traumagenic dynamics × disclosure were tested using a three-step regression approach. In two different hierarchical multiple regressions, all the characteristics of the abuse (type of abuse, relationship with the perpetrator and continuity of abuse, the age of the perpetrator and the existence of disclosure) and the occurrence of other maltreatments were entered in the first step, the four traumagenic dynamics in a second step, and the interaction term (the product of traumagenic dynamics and the age of the perpetrator, for the first multiple regression, or the existence of disclosure for the second one) in a third step. Significant interactions are shown in Tables 3 and 4.

Table 3.
Significance tests of the moderating effect of the age of the perpetrator on the relationship between feelings provoked by abuse and PTSD symptoms in CSA survivors

Variable	Adjusted R^2	$F\ \Delta$	*Error tip.*	Beta	*t*
Step 1	.126	3.870	9.534		
Type			1.445	.241	2.769 **
Continuity			1.819	.178	1.979*
Step 2	.329	10.908 ***	8.307		
Stigma			.060	.185	1.969 *
Betrayal			.120	.178	2.101 *
Powerlessness			.132	.230	2.405 *
Step 3	.355	2.096 *	8.161		
Stigma			.173	.734	2.703 **
Stigma * Perpet age			.110	-.587	-2.131 *
Traumatic sexual.* Perpet age			.385	.653	2.580 **

$p < .05$; ** $p < .01$; *** $p < .001$. *Note:* Only significant results are reported

When the interaction of the age of the perpetrator (minor (< 18) vs. adult (≥ 18)) with traumagenic dynamics was added as a predictor, 35% of the total variance in PTSD

was accounted for (Table 3, step 3). The results support an interactive role of this CSA characteristic with traumagenic dynamics. Broken down further, an interaction with the stigma (β = -.587, p < .05) and the traumatic sexualization score (β = .653, p < 0.01) can account for this result. A single effect of stigma was also found (β = .734, p < .01).

Table 4.
Significance tests of the moderating effect of the existence of disclosure on the relationship between feelings provoked by abuse and PTSD symptoms in CSA survivors

Variable	Adjusted R^2	$F\ \Delta$	*Error tip.*	Beta	*t*
Step 1	.126	3.870	9.534		
Type			1.445	.241	2.769 **
Continuity			1.819	.178	1.979*
Step 2	.329	10.908 ***	8.307		
Stigma			.060	.185	1.969 *
Betrayal			.120	.178	2.101 *
Powerlessness			.132	.230	2.405 *
Step 3	.361	2.499 *	8.109		
Stigma			.069	.254	2.345 *
Betrayal			.144	.385	3.006 **
Betrayal * Disclosure			.245	-.205	-1.997 *
Traumatic sexual.* Disclosure			.441	.229	2.328 *

p < .05; ** p < .01; *** p < .001. *Note:* Only significant results are reported

Finally, regarding the effect of the existence of a disclosure, there was a significant effect of this variable resulting from the interaction of disclosure and betrayal (β = -.205, p < .05) and disclosure and traumatic sexualization (β = .229, p < .05). These variables, together with the stigma (β = .254, p < .05) and betrayal (β = .385, p < .01) explained 36% of the variance on PTSD score.

With the knowledge that the relationship between the traumagenic dynamics and the PTSD score would vary depending on the age of the perpetrator and the existence of disclosure, and that the difference was statistically significant, two independent multiple regression analyses were carried out in order to determine whether the moderated relationship conformed to the pattern of relationship hypothesized (Table 5). To this end, the sample was divided according to the age of the perpetrator (minor (< 18) vs. adult (≥ 18), and the existence of disclosure (disclosure vs. non-disclosure). The four traumagenic dynamics scores, the characteristics of abuse and the occurrence of other maltreatments were introduced as predicting variables.

Table 5.
Association between feelings provoked by abuse and PTSD according to the age of the perpetrator and the existence of disclosure

CSA Characteristic	Category	*Adjusted* R^2	*Error tip.*	*F*	*p*
Perpetrator age	Minor 18	.193	9.497	2.804	.008
	Mayor 18	.476	7.081	7.248	.000
Disclosure	Non disclosure	.297	8.827	5.133	.000
	Disclosure	.500	6.797	7.671	.000

In the case of the age of the perpetrator, the relation between traumagenic dynamics and PTSD was stronger when the perpetrator was older 18 than when he was under than 18 (Adjusted R^2 = .476, p < .001 *vs.* Adjusted R^2 = .193, p < .008, respectively). In this case, although there was an effect of stigma in the case of abuse committed by a minor but not an adult (β = .328, p < .05 *vs.* β = .033, p < .790, respectively), traumatic sexualization had an effect when the perpetrator was an adult but not a minor (β = .057, p < .649 *vs.* β = .427, p < .01, respectively).

Finally, with regard to disclosure, the relationship with PTSD score was stronger in those cases where the survivor disclosed the abuse than when she kept it hidden (Adjusted R^2 = .500, p < .000 *vs.* Adjusted R^2 = .297, p < .000). Here, while there was an effect of betrayal when abuse was hidden but not when abuse was disclosed (β = .294, p < .01 *vs.* β = -.172, p < .303), again the effect of traumatic sexualization appeared when the survivor disclosed the abuse but not when the survivor hid the abuse (β = .044, p < .666 *vs.* β = .535, p < .01).

Discussion

The implementation of intervention strategies focused on the factors that are most relevant to the harmful effects of CSA is necessary to diminish the impact of abuse (Daigneault, Hébert, & Tourigny, 2006; Pereda, 2009). The present study investigated which factors involved in CSA are most harmful by examining the relationships between the feelings provoked by CSA and the development of symptoms of PTSD in a sample of female college students.

The results of the present study suggest that, when controlling for the effects of other maltreatments and the characteristics of the abuse, the PTSD scores of the survivors were predicted by the feelings of stigma, betrayal and powerlessness. Clearly, feelings of stigma regarding CSA can linger long into adulthood. This sense of feeling ashamed, tainted, and blameworthy in regards to the abuse may impact adjustment by affecting a woman's core beliefs about their self-worth. Struggling with these feelings may result in heightened levels of psychological distress (Thoresen & Øverlien, 2009; Coffey et al, 1996). The relationship between stigma and psychological adjustment has been found in the majority of studies that analyze

the isolated role of this variable (e. g., Feiring et al., 2009; Kim et al., 2009). However, results of studies that have taken several traumatogenic dynamics into account simultaneously, have been contradictory. Although Dufour and Nadeau (2001), and Coffey et al. (1996) found a relationship between stigma and psychological adjustment, Hazzard et al. (1995) did not find this relationship. The negative finding in the Hazzard et al. (1995) study may be due to the age of the participants; it is the only study that uses young (8 to 13 years old) girls. Therefore, stigma may play a more salient role in mediating adjustment during adulthood than it does in childhood. In turn, Kallstrom-Fuqua et al. (2004) found that stigma was related to a measure of psychological distress but not to the interpersonal difficulties of the survivors.

Research concerning the other traumagenic dynamics is limited. In the present study, a feeling of powerlessness was the traumagenic dynamic most strongly related to the PTSD symptomatology of the survivors. This result agrees with that of Hazzard et al. (1995), who found that powerlessness was the only dynamic associated with psychological distress, and Kallstrom-Fuqua et al. (2004), who found that powerlessness was the only dynamic related to interpersonal difficulties.

Regarding betrayal, our study is the first to simultaneously analyze the role of all four traumagenic dynamics and to report a significant relationship to the psychological adjustment of the CSA survivors (e. g., Coffey et al., 1996; Hazzard et al., 1995; Kallstrom-Fuqua et al., 2004). Kallstrom-Fuqua et al. (2004), for example, did not find the expected relationship of betrayal with interpersonal difficulties and psychological distress. Finally, although marginally significant, no statistically

significant relationship was found between traumatic sexualization and the PTSD symptomatology of the CSA survivors.

It is noteworthy that, in the present study, there was no single direct effect of any CSA characteristic (or the existence of other maltreatments) on PTSD symptomatology. Although we found that the type and continuity of abuse were related to the PTSD score of survivors, these effects disappeared when taking into account the effects of traumagenic dynamics. However, these results are in agreement with other research that has suggested that social, environmental and cognitive factors may be more important than the characteristics of abuse when predicting the adjustment of CSA survivors (e. g., Paolucci, Genuis, & Violato, 2001; Quas et al., 2003). Because psychological adjustment after CSA is mediated by cognitive and affective factors the potential for effective intervention among survivors is promising (Bal, Van Oost, De Bourdeaudhuij, & Crombez, 2003).

As predicted, the role of traumagenic dynamics varied substantially when taking into account their interactive effects with the age of the perpetrator and the existence of disclosure. The relationship between traumagenic dynamics and PTSD score was stronger when abuse was committed by an adult perpetrator, and when there had been a disclosure during (or a short time after) the abuse. When the sample was divided according to the age of the perpetrator, an effect of stigma was found in the case of abuse committed by a minor (< 18), whereas an effect of traumatic sexualization appeared in the case of abuse committed by an adult (≥ 18). Finally, regarding the existence of disclosure, a role of betrayal was found when abuse was hidden, while there was an effect of traumatic sexualization on PTSD symtptomatology in cases of abuse that had been disclosed. It is noteworthy that there was no significant effect of traumatic sexualization on the PTSD symptomatology when the sample was analyzed as

a whole, but that this relationship surfaced when dividing the sample according to the age of perpetrator and disclosure. Therefore, the present results suggest that, both the age of the perpetrator and the existence of a disclosure are valuable factors in predicting the impact of traumagenic dynamics on psychological adjustment of CSA survivors. These factors, therefore, should be taken into consideration when designing clinical interventions.

Our findings suggest that it is necessary to take into account the feelings provoked by CSA when giving therapeutic assistance to female adult survivors. The development of clinical interventions specifically designed to assess and diminish the feelings of stigma, powerlessness, betrayal and traumatic sexualization may be beneficial in treating PTSD symtptomatology of women survivors of CSA. These interventions should be based on the ability to freely express emotions, the gradual exposure to negative emotions, and the development of a therapeutic environment where emotions provoked by the abuse can be expressed and re-evaluated (Feiring & Cleland, 2007). Consequently, interventions may help survivors identify and counteract distorted perceptions as a result of trauma. For example, one approach may include helping survivors identify positive personal attributes and reinforce the belief that the CSA was not their fault, thereby decreasing the perceptions and emotions associated with stigmatization. Another goal may be assisting survivors to identify or initiate positive relationships and emphasize the benefits of those relationships, with the intention to prevent or decrease feelings of betrayal. To decrease thoughts and feelings of powerlessness, helping women to set and accomplish reasonable goals and identify successful experiences may be beneficial. Finally, to cope with the effects provoked by traumatic sexualization, it may be helpful to diminish a survivor´s confusion and anxiety regarding sex. In the case of children, this may include an increase in a

developmentally appropriate parent-child communication about topics related to sex. Overall, it is important that professionals be aware of the effects of betrayal, powerlessness, stigmatization and traumatic sexualization on adjustment after sexual abuse (Kallstrom-Fuqua et al., 2004).

There are a number of limitations to the current study that must be considered. First, the study is cross-sectional and uses a single source of information to assess both the feelings provoked by abuse and the PTSD symptomatology of the survivor. In the absence of a prospective design beginning when the abuse first occurred, it is not possible to determine cause and effect (Calvete, Estévez, & Corral, 2007; Decker, Raj, & Silverman, 2007). In other words, it is impossible to know whether feelings (resulting from the abuse) influence PTSD or whether PTSD influences feelings. Longitudinal studies using information gathered from people other than those who provide information about mediator mechanisms could possibly elucidate the stability and the direction of the relationship between the different variables (Bal et al., 2003). Future work using a longitudinal design in which feelings provoked by the abuse are assessed along with symptoms over time will be important for understanding how abuse-specific processes may operate to increase the risk for PTSD (Parker & Lee, 2007).

Another possible limitation of the study concerns the generalization of the findings. Our study was restricted to a college sample, composed of participants who may function at a higher cognitive level than other groups (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996). However, it is possible that our sample is less biased than a clinical sample and therefore, our subjects may be more reliable in reporting the characteristics of the CSA (Gorey & Leslie, 1997). Finally, one last limitation is related to the use of retrospective reports. However, previous studies have shown that the small amount of bias present in retrospective reports is not strong enough to invalidate

research on major adversities (Hardt & Rutter, 2004). As Bifulco, Moran, Baines, Bunn, and Stanford (2002) note, there are certain merits to undertaking a retrospective study. There are fewer ethical issues in studying abuse that occurred a number of years prior to the study. Second, long-term consequences can be assessed along with characteristics of the abuse (Alexander, Quas, Goodman, Ghetti, Edelstein, Redlich et al., 2005). Lastly, many survivors of CSA disclose tardily, if at all, since only a minority of people who have been sexually abused report abuse during childhood (Cortés & Cantón, 2008).

In conclusion, and regardless of these limitations, the present study identified a number of areas for the therapeutic treatment of female survivors of CSA. Diminishing negative feelings provoked by the abuse, as reflected by the traumagenic dynamics model proposed by Finkelhor and Browne (1985) may have a positive role in diminishing PTSD symptomatology, especially in cases where abuse was committed by an adult perpetrator and when the victim disclosed the abuse early on.

GENERAL DISCUSSION

1.1. Summary of the results and discussion

The aim of the present Thesis was to determine the role of cognitive variables on PTSD symptomatology in a sample of female college students who were victims of CSA. With this aim, the role of coping strategies and attributions of blame was analyzed, and a model that included the interaction of both variables was tested. Finally, the role of a third moderator variable, the feelings provoked by the abuse, was examined. Due to the role they can exert on psychological adjustment (Grassi-Oliveira & Stein, 2008; Hazen, Connelly, Roesch, Hough & Landsverk, 2009), other physical and emotional maltreatments and neglect were controlled for through the four studies included in the Thesis.

Before analyzing the role of cognitive variables, we analyze the relationship between CSA and the PTSD symptomatology by comparing the PTSD scores of CSA victims with the scores of a group that had not suffered abuse (study 1). The results agreed with prior research findings (Spitalnick et al., 2008) in that, as a group, CSA victims have more psychological difficulties assessed by TEP symptomatology.

Coping strategies and psychological adjustment

With regard to the first variable, the strategies employed by the victim to cope with the abuse, we tried to examine the independent effects on the PTSD of the approach and avoidance strategies. In accordance with results from prior studies (e.g., Hébert et al., 2006; Merrill et al., 2003; Wright et al., 2007), we found that avoidance (but not approach) strategies are related to a worse adjustment outcome. The failure of approach coping strategies to produce the expected improvement in functioning may be due to the absence of other required factors for this strategy to be effectively deployed.

Tactics necessary for the successful use of approach strategies involve the expression of feelings and effort to improve the situation. The accessibility of these factors depend on the availability of social and material resources and may give the victim greater actual or perceived control over the environment. For example, the expected positive impact of social support may depend on the quality and type of support received (Stevenson, Maton, & Teti, 1999). Thus, seeking support without a responsive support system being available may be associated with greater distress (Daigneault et al., 2006).

An intrinsic problem of retrospective studies that maintain the anonymity of participants is the use of a single information source to assess both coping and adjustment. It could be argued that people with poorer psychological adjustment, whether victims of CSA or not, may tend to more often report the use of avoidance coping strategies than approach strategies and this could possibly account for the obtained results on the effects of coping strategies on psychological adjustment. To investigate this issue, one objective of the research was to obtain results that would rule out the hypothesis of a bias due to measuring both variables concurrently. With this aim we tested: a) the effects of the CSA on the employment of coping strategies, b) the existence of an interaction of coping strategies with the continuity of the abuse and the relationship with the perpetrator, and c) the existence of an interaction of coping strategies with the CSA status (CSA victim vs. non-CSA victim).

The assumption that CSA victims are more likely to use non-adaptive coping strategies was only partially supported by our results. Although non-CSA participants reported a higher frequency of approach strategies than CSA victims, the results regarding avoidance strategies were not consistent. CSA participants reported significantly higher levels of evasion coping, but they also reported significantly lower

levels of nervous coping, while there was no significant difference between the two groups in self-destructive coping.

There was a significant interactive effect of coping strategies with the continuity of the abuse and the relationship with the perpetrator such that, the correlation between coping strategies and PTSD was stronger in the case of continuous abuse and abuse committed by a member of the family. Additionally, there was a significant interaction between coping strategies and adjustment on CSA in that the relationship between coping and PTSD was stronger in the case of CSA victims than in the case of participants who had not suffered CSA. Taken together, these findings suggest that the role of avoidance coping strategies on PTSD cannot be explained by the assumption that poorer adjustment leads to higher scores on avoidance strategies and lower scores on approach coping.

Attributions of blame and psychological adjustment

The aim of Study 2 was to examine the role of attributions of blame for the abuse in psychological adjustment. Specifically, the role of self blame, perpetrator blame and family blame on PTSD symptomatology was analyzed. The findings suggest that, consistent with previous studies (e. g., Filipas & Ullman, 2006; Steel et al., 2004), self blame attributions predict the PTSD score of CSA victims. Our results are also consistent with McMillem and Zuravin´s (1997) study, finding a positive correlation between scores on family blame and a risk of presenting symptoms of PTSD. Interestingly, we found no correlation between blaming the abuser and lower PTSD severity. This result is in conflict with previous clinical literature that has emphasized perpetrator blame over blame of family members as a means of lowering PTSD symptomatology (Celano et al., 2002). However, in spite of this emphasis in the

literature, other studies (e. g., Feiring & Cleland, 2007; McMillem & Zuravin, 1997) have also failed to find a relationship between perpetrator blame and the psychological adjustment of the victim. Thus, it may be suggested that altering blame to perpetrator blame is not a useful tool in decreasing self-blame attributions. As no significant correlation was found in the present or other studies, it cannot be assumed that encouraging young people to make perpetrator blame attributions will diminish the probability that they will make blame attributions towards themselves (Celano et al., 2002; Feiring & Cleland, 2007).

As we did with the coping strategies, and with the aim of testing that the effects of the attributions of blame on the PTSD are not due to the fact that people with poorer adjustment present a greater tendency to self blame and family blame and are less likely to blame the perpetrator (Daigneault et al., 2006; Feiring, Taska, & Chen, 2002), the interactive effects of the attributions with the characteristics of the abuse were analyzed. An analysis of the interaction between attributions of blame and abuse characteristics on psychological adjustment showed an interactive effect of the attributions of blame with the continuity of the abuse, the relationship with the perpetrator and the type of acts suffered. The relationship between the attributions of blame and PTSD symptomatology was stronger in cases where more severe acts had been committed. However, contrary to our hypothesis, we found that the relationship was also stronger in the case of abuse consisting of an isolated incident and incidents committed by a non-family member. It may be proposed that factors (e.g., coping strategies) other than attribution of blame may have had a more important role in the recovery of CSA victims in the continued abuse and intra-familial abuse categories. In any case, these findings cannot be explained by a bias due to the measurement of both variables simultaneously.

Prediction of PTSD symptomatology

The aim of study 3 was to design and test a model for predicting victim PTSD symptomatology by the characteristics of abuse, the existence of other maltreatments, the attributions of self blame and family blame and avoidance coping strategies. Only avoidance coping, self blame and family blame were selected as possible mediators, since approach coping strategies and perpetrator blame attributions have been consistently found to have little or no impact on survivor recovery (e. g., Feiring & Cleland, 2007; Hébert et al., 2006; Wright et al., 2007). Following the obtained model, the severity of abuse (assessed in term of continuity, the relationship with the perpetrator and the type of acts committed) is correlated with the attributions of self blame and family blame. Similarly, the presence of other maltreatments increases the attributions of blame towards the family, but not self blame. Both attributions of blame, conversely, are related to a higher use of avoidance coping strategies, which led to a higher severity of PTSD symptomatology.

As a group, our studies highlight the importance of attributions of blame and coping strategies as moderating factors on the impact of CSA. Both variables may be useful in the identification of CSA victims who are at an increased risk for ongoing trauma related symptoms. For example, women with a more severe history of CSA who engage in self blame and family blame and women who tend to use avoidant coping behavior may suffer a higher level of PTSD symptomatology. In addition, these moderating factors may be helpful in clinical practice. The strong relationships between attributions of blame, coping strategies and long-term psychological adjustment suggest that early intervention with children who have suffered CSA focused on the modification of the attributions they make about the abuse and the way they cope with it may lead to a better prognosis. A reduction in feelings of self blame and family blame,

as well as a decrease in avoidant coping strategies, may have beneficial effects on reducing PTSD symptomatology.

Effects of other cognitive factors

Although coping strategies and attributions of blame have been given the most attention in prior research, there are additional cognitive variables that can have an effect on the psychological adjustment of CSA victims. The traumagenic dynamics model (Finkelhor & Browne, 1985) is one of the most recognized models in the field of CSA. This model poses that the effects of CSA on psychological adjustment are due to four trauma-causing factors: powerlessness, betrayal, stigmatization and traumatic sexualization. In Study 4 we tested the effects of these four factors on PTSD symptomatology, as examples of other relevant variables for the effects of abuse. With this aim, as was done with the coping strategies and attributions of blame, the interactions of the 4 dynamics with characteristics of the abuse on psychological adjustment were analyzed. In this case, and with the aim of testing if the interactions of the cognitive variables occur with other different characteristics apart from the type, continuity of the abuse and relationship with the perpetrator, the interactions with two other characteristics were analyzed: the age of the perpetrator and the existence or absence of a disclosure during or a short time after the abuse.

Results of the study found roles for the feelings of powerlessness, betrayal and stigma on PTSD symptomatology when analyzing the entire group of CSA victims. The role of traumatic sexualization was only relevant when it was analyzed in interaction with the age of the perpetrator and disclosure. Thus, the effects of the feelings provoked by abuse were stronger in the case of an adult perpetrator, as well as when there was disclosure at the time of abuse or a short time after it finished. These findings suggest

that it would be beneficial to develop clinical interventions specifically designed to take into account and diminish the feelings of stigma, powerlessness, betrayal and traumatic sexualization provoked by CSA when giving therapeutic assistance to female adult CSA survivors. These interventions should be based on the ability to freely express emotions, the gradual exposure to negative emotions, and the development of a therapeutic environment where emotions provoked by the abuse can be expressed and re-evaluated (Feiring & Cleland, 2007).

Taken together, the findings presented in this Thesis highlight the importance of several flexible cognitive variables of CSA victims that can have a role in recovery from abuse. Clinical intervention with victims of CSA should take into account the attributions of blame used by the victim, the coping strategies he/she employed and feelings provoked by the abuse in an attempt to modify dysfunctional patterns. Moreover, the current thesis identified under which characteristics of abuse these cognitive variables have a greater relevance, elucidating the conditions under which this type of therapy would be most beneficial.

1.2. Future research

In the present set of studies, the effects of several cognitive variables on PTSD symptomatology were assessed in CSA victims. Although PTSD has been shown to be one of the most prevalent consequences of CSA, the abuse can provoke a broad variety of devastating effects. Future research should investigate the effects of the cognitive variables examined in the present thesis on psychological maladjustments other than PTSD such as behavioral or sexual disorders.

Research on the effects of characteristics of abuse has found inconsistent results regarding the relationship between these variables and the psychological adjustment of victims (e. g., Paolucci et al., 2001; Quas et al., 2003). In addition, the characteristics of abuse are unchangeable and therefore, are ineffective for use in a clinical setting. The present Thesis focused on the study of a group of cognitive variables of the CSA victim that have been suggested to influence psychological adjustment. Another group of variables, environmental factors, could also have an influence on the adjustment of victims (Marivate & Madu, 2007; McClure et al., 2008). As with cognitive factors, environmental factors are amendable to change, and therefore they are of utility from a clinical stand point. The family environment, social support, and factors related to the intervention of the community have been studied (Eisenberg et al., 2007; Marivate y Madu, 2007). Future studies should analyze how these variables may interact with the characteristics of abuse to further understand which circumstances have a greater impact on the victim and should receive attention in a clinical setting.

Finally, these studies suggest that several characteristics of abuse (such as continuity of abuse, type of acts committed, relationship with the perpetrator, age of the perpetrator and the existence of a disclosure) interact with the cognitive variables used by the victim. However, it is possible that other characteristics such as the sex of the perpetrator or the victim (which we could not analyze because our participants were all female victims of mainly male perpetrators), could also have an interactive effect with coping strategies, attributions of blame or feelings provoked by the abuse. Future research should consider these interactions in study design.

1.3. Limitations

There are a number of limitations to the current set of studies that must be considered. First, the use of retrospective reports has been linked to certain biases concerning the memory of the CSA experience. There exists the possibility that the victim may redefine his/her own behaviors as a function of subsequent experiences and knowledge (Widom & Morris, 1997). However, several studies support the usefulness of retrospective research on major adversities, demonstrating that the small amount of bias present in retrospective self-reports is not strong enough to invalidate this model (e.g., Johnson, Ross, Taylor, Williams, Carvajal, & Peters, 2006; Paivio, 2001). Moreover, there is a broad consensus that many victims of CSA disclose their experience tardily, if at all. In fact, it has been suggested that more than 90% of victims of CSA never report the abuse (Cortés & Cantón, 2008; Hershkowitz, Horowitz, & Lamb, 2005). Therefore, retrospective reports may be the most reliable method of obtaining information about CSA cases (Helweg-Larsen & Larsen, 2005).

The correlational design of this thesis prevents causal interpretations. To overcome this limitation, we studied the interactive role of the characteristics of abuse. Future research would benefit from longitudinal analyses to examine the strength and direction of causal relationships between cognitive variables and psychological adjustment among CSA victims and to compare trends and health outcomes over time. The present findings should be replicated through a longitudinal design, as it would avoid the problems associated with retrospective reports and would allow for an examination of the possibility that the investigated variables change in the aftermath of the abusive experience (Parker & Lee, 2007).

Finally, generalizations about findings from student samples must be made with caution. However, the selection of a student sample avoids the distortions and memory deficits that older adults may have (Halperin, Bouvier, Jaffe, Monoud, Pawlak, Laederach et al., 1996). In addition, the change in societal attitudes towards several lifestyle habits may be a confusing factor and it was for this reason that the age of our participants was limited to 24 years. Moreover, despite the possible bias of CSA prevalence rates in a college student sample, this population is most likely less biased than a clinical one, therefore a broader and more extensive report on the characteristics of the CSA could be studied (Gorey & Leslie, 1997).

REFERENCIAS

Alexander, K. W., Quas, J. A., Goodman, G. S., Ghetti, S., Edelstein, R. S., Redlich, A. D., Cordon, I. M. y Jones, D. P. H. (2005). Traumatic impact predicts long-term memory for documented child sexual abuse. *Psychological Science, 16*, 33-40.

Allen, J. G., Coyne, L. y Huntoon, J. (1998). Complex posttraumatic stress disorder in women from a psychometric perspective. *Journal of Personality Assessment, 70*, 277–298.

Aspelmeier, J. E., Elliott, A. N. y Smith, C. H. (2007). Childhood sexual abuse, attachment, and trauma symptoms in college females: The moderating role of attachment. *Child Abuse & Neglect, 31*, 549-566.

Bailey, J. A. y McCloskey, L. A. (2005). Pathways to adolescent substance use among sexually abused girls. *Journal of Abnormal Child Psychology, 33*, 39-53.

Bal, S., Van Oost, P., De Bourdeaudhuij, I. y Crombez, G. (2003). Avoidant coping as a mediator between self-reported sexual abuse and stress-related symptoms in adolescents. *Child Abuse & Neglect, 27*, 883-897.

Barker-Collo, S. L. (2001). Adult reports of child and adult attributions of blame for childhood sexual abuse: Predicting adult adjustment and suicidal behaviors in females. *Child Abuse & Neglect, 25*, 1329-1341.

Baron, S. W. (2004). General strain, street youth and crime: A test of Agnew's revised theory. *Criminology, 42*, 457-483.

Berliner, L. (2000). What is sexual abuse? En H. Dubowitz y D. DePanfilis (Eds.) *Handbook for Child Protection.* Thousands Oaks, CA: Sage.

Berliner, L. y Elliott, D. M. (2002). Sexual abuse of children. En Myers, J. E. B., Berliner, L., Briere, J., Hendrix, C. T., Jenny, C. y Reid, T. A. (eds.), *The APSAC Handbook on Child Maltreatment*. Thousand Oaks, CA: Sage

Bifulco, A., Moran, P. M., Baines, R., Bunn, A. y Stanford, K. (2002). Exploring psychological abuse in childhood: II. Association with other abuse and adult clinical depression. *Bulletin of the Menninger Clinic, 66*, 241-258.

Boden, J. M., Horwood, L. J. y Fergusson, D. M. (2007). Exposure to childhood sexual and physical abuse and subsequent educational achievement outcomes. *Child Abuse & Neglect, 31*, 1101-1114.

Bonomi, A. E., Cannon, E. A., Anderson, M. L., Rivara, F. P. y Thompson, R. S. (2008). Associations between self-reported health and physical and/or sexual abuse experienced before age 18. *Child Abuse & Neglect, 32*, 693-701.

Brand, B. L. y Alexander, P. C. (2003). Coping with incest: The relationship between recollections of childhood coping and adult functioning in female survivors of incest. *Journal of Traumatic Stress, 16*, 285-293.

Briere, J. (1996). *Therapy for adults molested as children (2nd ed.).* New York: Springer.

Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. En J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, T. Reid y C. Jenny (Eds.). *The APSAC handbook on child maltreatment, 2nd Edition* (pp. 175-203). Newbury Park, CA: Sage.

Briere, B. y Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect, 27*, 1205-1222.

Briere, J. y Scott, C. (2006). *Principles of trauma therapy. A guide to symptoms, evaluation and treatment.* Thousand Oaks: Sage.

Buckle, S. K., Lancaster, S., Powell, M. B. y Higgins, D. J. (2005). The relationship between child sexual abuse and academic achievement in a sample of adolescent psychiatric inpatients. *Child Abuse & Neglect, 29*, 1031-1047.

Bunting, L. (2008). Sexual offences against children: An exploration of attrition in the Northern Ireland criminal justice system. *Child Abuse & Neglect, 32*, 1109-1118.

Burt, M. R. y Katz, B. L. (1987). Dimensions of recovery from rape: Focus on growth outcomes. *Journal of Interpersonal Violence, 2*, 57-81.

Butzel, J. S., Talbot, N. L., Duberstein, P. R., Houghtalen, R. P., Cox, C. y Giles, D. E. (2000). The relationship between traumatic events and dissociation among women with histories of childhood sexual abuse. *The Journal of Nervous and Mental Disease, 188*, 547-549.

Cachelin, F. M., Schug, R. A., Juarez, L. C. y Monreal, T. K. (2005). Sexual abuse and eating disorders in a community sample of mexican american women. *Hispanic Journal of Behavioral Sciences, 27*, 533-546.

Calvete, E., Estévez, A., y Corral, S. (2007). Trastorno por estrés postraumático y su relación con esquemas cognitivos disfuncionales en mujeres maltratadas. *Psicothema, 19*, 446-451.

Cantón, D. y Cantón, J. (2010). Coping with child sexual abuse among college students and Post-traumatic Stress Disorder: The role of continuity of abuse and relationship with the perpetrator. *Child Abuse & Neglect.* En prensa.

Cantón, D., Cantón, J. y Justicia, F. (2010) The interactive effect of blame attribution with characteristics of Child Sexual Abuse on Post-traumatic Stress Disorder. Manuscrito enviado para publicación.

Cantón, D., Cantón, J., Cortés, M. R. y Justicia, F. (2010). The effects of perpetrator age and abuse disclosure on the relationship between feelings provoked by Child Sexual Abuse and Post-traumatic Stress. Manuscrito enviado para publicación.

Cantón, D., Cantón, J., Justicia, F. y Cortés, M. R. (2010). Un modelo de los efectos del Abuso Sexual Infantil sobre el Estrés Post-traumático: El rol mediador de las atribuciones de culpa y estrategias de afrontamiento. Manuscrito enviado para publicación.

Cantón, J., y Cortés, M. R. (2008). Consecuencias del abuso sexual infantil. En Cantón, J., y Cortés, M. R., *Guía para la evaluación del abuso sexual infantil*. Madrid: Pirámide.

Cantón, D. y Justicia, F. (2008). Afrontamiento del abuso sexual infantil y ajuste psicológico a largo plazo. *Psicothema, 20*, 509-515.

Celano, M., Hazzard, A., Campbell, S. y Lang, C. (2002). Attribution retraining with sexually abused children: Review of techniques. *Child Maltreatment, 7*, 65-76.

Chaffin, M., Wherry, J. N. y Dykman, R. (1997). School age children´s coping with sexual abuse: Abuse stresses and symptoms associated with four coping strategies. *Child Abuse & Neglect, 21*, 227-240.

Chandy, J. M., Blum, R. W. y Resnick, M. D. (1996). Gender-specific outcomes for sexually abused adolescents. *Child Abuse & Neglect, 20*, 1219-1231.

Chelfa, C. M., y Ellis, J. B. (2002). Young adults who were sexually abused: Demographics as predictors of their coping behaviors. *Child Abuse & Neglect, 26*, 313-316.

Chen, J. Q., Dunne, M. P. y Han, P. (2006). Child sexual abuse in Henan province, China: Associations with sadness, suicidality, and risk behaviors among adolescent girls. *Journal of Adolescent Health, 38*, 544-549.

Choi, H., Klein, C., Shin, M. y Lee, H. (2009). Posttraumatic stress disorder (PTSD) and disorders of extreme stress (DESNOS) symptoms following prostitution and childhood abuse. *Violence Against Women, 15*, 933-951.

Chromy, S. (2006). Sexually abused children who exhibit sexual behavior problems: Victimization characteristics. *Brief Treatment and Crisis Intervention, 7*, 25-33.

Coffey, P., Leitenberg, H., Henning, K., Turner, T. y Bennett, R. T. (1996). Mediators of the long-term impact of child sexual abuse: Perceived stigma, betrayal, powerlessness, and self-blame. *Child Abuse & Neglect, 20*, 447-455.

Cohen, T. (1995). Motherhood among incest survivors. *Child Abuse & Neglect, 19*, 1423-1429.

Collin-Vézina, D. y Hébert, M. (2005). Comparing dissociation and PTSD in sexually abused school-aged girls. *Journal of Nervous & Mental Disease, 193*, 47-52.

Cortés, M. R. y Cantón, J. (2008). El abuso sexual infantil: Un grave problema social. En J. Cantón y M. R. Cortés, *Guía para la evaluación del abuso sexual infantil* (pp. 13-52). Madrid: Pirámide.

Craissati, J., McClurg, G. y Browne, K. (2002). Characteristics of perpetrators of Child Sexual Abuse who have been sexually victimized as children. *Sexual Abuse: A Journal of Research and Treatment, 14*, 225-239.

Daigneault, I., Hébert, M. y Tourigny, M. (2006). Attributions and coping in sexually abused adolescents referred for group treatment. *Journal of Child Sexual Abuse, 15*, 35-59.

Daigneault, I., Tourigny, M. y Hébert, M. (2006). Self-attributions of blame in sexually abused adolescents: A mediational model. *Journal of Traumatic Stress, 19*, 153-157.

Davis, J. L. y Petretic-Jackson, P. A. (2000). The impact of child sexual abuse on adult interpersonal functioning: A review and synthesis of the empirical literature. *Aggression and Violent Behavior, 5,* 291-328.

DeBellis, M. D., Chrousos, G. P., Dorn, L. D., Burke, L., Helmers, K., Kling, M. A., et al. (1994). Hypothalamic–pituitary–adrenal axis dysregulation in sexually abused girls. *Journal of Clinical Endocrinology and Metabolism, 78,* 249-255.

De Paúl, J., Milner, J. S. y Múgica, P. (1995). Childhood maltreatment, childhood social support, and child abuse potential in a Basque sample. *Child Abuse & Neglect, 19,* 907-920.

Decker, M. R., Raj, A. y Silverman, J. G. (2007). Sexual violence against adolescent girls. Influences of immigration and acculturation. *Violence Against Women, 13,* 498-513.

Declerck, C. H., Boone, C. y De Brabander, B. (2006). On feeling in control: A biological theory for individual differences in control perception. *Brain and Cognition, 62,* 143-176.

Del Campo, A., y López, F. (2006). Evaluación de un programa de prevención de abusos sexual a menores en educación primaria. *Psicothema, 18,* 1-8.

Denov, M. S. (2004). The long-term effects of child sexual abuse by female perpetrators: A qualitative study of male and female victims. *Journal of Interpersonal Violence, 19,* 1137-1156.

Dhaliwal, G. K., Gauzas, L., Antonowicz, D. H. y Ross, R. R. (1996). Adult male survivors of childhood sexual abuse, prevalence, sexual abuse characteristics, and long term effects. *Clinical Psychology Review, 16,* 619-639.

DiLillo, D. (2001). Interpersonal functioning among women reporting a history of childhood sexual abuse: Empirical findings and methodological issues. *Clinical Psychology Review, 21*, 553-576.

Dufour, M. H. y Nadeau, L. (2001). Sexual abuse: A comparison between resilient victims and drug-addicted victims. *Violence and Victims, 16*, 655-672.

Echeburúa, E., Corral, P., Amor, P. J., Zubizarreta, I. y Sarasua, B. (1997). Escala de Gravedad de Síntomas del Trastorno de Estrés Postraumático: Propiedades psicométricas. *Análisis y Modificación de Conducta, 23*, 503-526.

Edinburgh, L., Saewyc, E. y Levitt, C. (2008). Caring for young adolescent sexual abuse victims in a hospital-based children's advocacy center. *Child Abuse & Neglect, 32*, 1119-1126.

Eisenberg, M. E., Ackard, D. M. y Resnick, M. D. (2007). *The Journal of Pediatrics, 151*, 476-481.

Fanslow, J. L., Robinson E. M., Crengle, S. y Perese, L. (2007). Prevalence of child sexual abuse reported by a cross-sectional sample of New Zealand women. *Child Abuse & Neglect, 31*, 935-945.

Feiring, C. y Cleland, C. (2007). Childhood sexual abuse and abuse-specific attributions of blame over 6 years following discovery. *Child Abuse & Neglect, 31*, 1169-1186.

Feiring, C., Miller-Johnson, S. y Cleland, C. M. (2007). Potential pathways from stigmatization and internalizing symptoms to delinquency in sexually abused youth. *Child Maltreatment, 12*, 220-232.

Feiring, C., Simon, V. A. y Cleland, C. M. (2009). Childhood sexual abuse, stigmatization, internalizing symptoms, and the development of sexual

difficulties and dating aggression. *Journal of Consulting and Clinical Psychology, 77*, 127-137.

Feiring, C., Taska, L. y Chen, K. (2002). Trying to understand why horrible things happen: Attribution, shame, and symptom development following sexual abuse. *Child Maltreatment, 7*, 26-41.

Ferguson, D. M., Boden, J. M y Horwood, L. J. (2008). Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child abuse & Neglect, 32*, 607-619.

Filipas, H. H. y Ullman, S. E. (2006). Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence, 21*, 652-672.

Finkelhor, D. y Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55*, 530-541.

Finkelhor, D. y Dziuba-Leatherman, J. (1994). Children as victims of violence: A national survey. *Pediatrics, 84*, 413-420.

Finkelhor, D., Ormrod, R., Turner, H. y Hamby, S. L. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment, 10*, 5-25.

Friedman, M. J., Jalowiec, J., McHugo, G., Wang, S. y McDonagh, A. (2007). Adult sexual abuse is associated with elevated neurohormone levels among women with PTSD due to childhood sexual abuse. *Journal of Traumatic Stress, 20*, 611-617.

Futa, K. T., Nash, C. L., Hansen, D. J. y Garbin, C. P. (2003). Adult survivors of childhood abuse: An analysis of coping mechanisms used for stressful childhood memories and current stressors. *Journal of Family Violence, 18*, 227-239.

Gallagher, B., Bradford, M. y Pease, K. (2008). Attempted and completed incidents of stranger-perpetrated child sexual abuse and abduction. *Child Abuse & Neglect, 32*, 517-528.

Gamble, S. A., Talbot, N. L., Duberstein, P. R., Conner, K. R., Franus, N. M., Beckman, A. M. y Conwell, Y. (2006). Childhood Sexual Abuse and depressive symptom severity: The role of neuroticism. *The Journal of Nervous and Mental Disease, 194*, 382-385.

Gannon, T. A. y Rose, M. R. (2008). Female child sexual offenders: Towards integrating theory and practice. *Aggression and Violent Behavior, 13*, 442-461.

Gault-Sherman, M., Silver, E. y Sigfúsdóttir, I. D. (2009). Gender and the associated impairments of childhood sexual abuse: A national study of Icelandic youth. *Social Science & Medicine, 69*, 1515-1522.

Gibb, B. E., Schofield, C. A. y Coles, M. E. (2009). Reported history of childhood abuse and young adults' information-processing biases for facial displays of emotion. *Child Maltreatment, 14*, 148-156.

Gold, S. N., Lucenko, B. A., Elhai, J. D., Swingle, J. M. y Sellers, A. H. (1999). A comparison of psychological/psychiatric symptomatology of women and men sexually abused as children. *Child Abuse & Neglect, 23*, 683-692.

Golding J. M., Wilsnack, S. C., Learman, L. A. (1998). Prevalence of sexual assault history among women with common gynecological symptoms. *American Journal of Obstetric Gynecology, 179*, 1013-1019.

Goodkind, S., Ng, I. y Sarri, R. C. (2006). The impact of sexual abuse in the lives of young women involved or at risk of involvement with the juvenile justice system. *Violence Against Women, 12*, 456-477.

Goodman-Brown, T. B., Edelstein, R. S., Goodman, G. S., Jones, D. P. H. y Gordon, D. S. (2003). Why children tell: A model of children disclosure of sexual abuse. *Child Abuse & Neglect, 27,* 525-540.

Gorey, K. M. y Leslie D. R. (1997). The prevalence of child sexual abuse: integrative review adjustment for potential response and measurement biases. *Child Abuse & Neglect, 21*, 391-8.

Grassi-Oliveira, R. y Stein, L. M. (2008). Childhood maltreatment associated with PTSD and emotional distress in low-income adults: The burden of neglect. *Child Abuse & Neglect, 32*, 1081-1138.

Hardt, J. y Rutter, M. (2004). Validity of adult retrospective reports of adverse childhood experiences: Review of the evidence. *Journal of Child Psychology and Psychiatry, 45,* 260-273.

Hartman, C. R. y Burgess, A. W. (1989). Sexual abuse on children: Causes and consequences. En D. Cichetti y V. Carlson (eds.), *Child Maltreatment: Theory and research on the causes and consequences of child abuse and neglect.* Cambridge: Cambridge University Press.

Halperin, D. S., Bouvier, P., Jaffe, P. D., Monoud, R. L., Pawlak, C. H. y Laederach, J. (1996). Prevalence of child sexual abuse among adolescent in Geneva: Results of a cross sectional survey. *British Medical Journal, 312,* 1326-1329.

Hanson, R. F., Resnick, H. S., Saunders, B. E., Kilpatrick, D. G. y Best, C. (1999). Factors related to the reporting of childhood rape. *Child Abuse & Neglect, 23,* 559-569.

Hazen, A. L., Connelly, C. D., Roesch, S. C., Hough, R. L. (2009). Child maltreatment profiles and adjustment problems in high-risk adolescents. *Journal of Interpersonal Violence, 24,* 361-378.

Hazzard, A., Celano, M., Gould, J., Lawry, S. y Webb, C. (1995). Predicting symptomatology and self-blame among child sexual abuse victims. *Child Abuse & Neglect, 19*, 707-714.

Hébert, M., Lavoie, F., Vitaro, F., McDuff, P. y Tremblay, R. E. (2008). Association of child sexual abuse and dating victimization with mental health disorder in a sample of adolescent girls. *Journal of Traumatic Stress, 21*, 181-189.

Hébert, M., Tremblay, C., Parent, N., Daignault, I. V. y Piché, C. (2006). Correlates of behavioral outcomes in sexually abused children. *Journal of Family Violence, 21*, 287-299.

Helweg-Larsen, K. y Larsen, H. B. (2005). A critical review of available data on sexual abuse of children in Denmark. *Child Abuse & Neglect, 29*, 715-724.

Henry, J. (1997). System intervention trauma to child sexual abuse victims following disclousure. *Journal of Interpersonal Violence, 12*, 499-512.

Hershkowitz, I., Horowitz, D. y Lamb, M. E. (2005). Trends in children's disclosure of abuse in Israel: A national study. *Child Abuse & Neglect, 29*, 1203-1214.

Hooper, C. y Warwick, I. (2006). Gender and the politics of service provision for adults with a history of childhood sexual abuse. *Critical Social Policy, 26*, 467–479.

Hyman, S. M., Gold, S. N. y Cott, M. A. (2003). Forms of social support that moderate PTSD in childhood sexual abuse survivors. *Journal of Family Violence, 18*, 295-300.

Janoff-Bulman, R. (1979). Characterological versus behavioral self-blame: Inquiries into depression and rape. *Journal of Personality and Social Psychology, 37*, 1798-1809.

Johnson, R. J., Rew, L. y Kouzekanani, K. (2006). Gender differences in victimized homeless adolescents. *Adolescence, 41*, 39–53.

Jonzon, E. y Lindblad, F. (2006). Risk factors and protective factors in relation to subjective health among adult female victims of child sexual abuse. *Child Abuse & Neglect, 30,* 127-143.

Kallstrom-Fuqua, A. C., Weston, R. y Marshall, L. L. (2004). Childhood and adolescent sexual abuse of community women: Mediated effects on psychological distress and social relationships. *Journal of Consulting and Clinical Psychology, 72*, 980-992.

Katerndahl, D., Burge, S. y Kellogg, N. (2005). Predictors of development of adult psychopathology in female victims of Childhood Sexual Abuse. *Journal of Nervous & Mental Disease, 193*, 258-264.

Kendler, K. S., Kuhn, J. W. y Prescott, C. A. (2004). Childhood sexual abuse, stressful life events and risk for major depression in women. *Psychological Medicine, 34*, 1475-1482.

Kim, J., Talbot, N. L. y Cicchetti, D. (2009). Childhood abuse and current interpersonal conflict: The role of shame. *Child Abuse & Neglect, 33*, 362-371.

Kingston, S. y Raghavan, C. (2009). The relationship of sexual abuse, early initiation of substance use, and adolescent trauma to PTSD. *Journal of Traumatic Stress, 22*, 65-68.

Kogan, S. M. (2005). The role of disclosing child Sexual abuse on adolescent adjustment and revictimization. *Journal of Child Sexual Abuse, 14*, 25-47.

Kuehnle, K. (1998). Child sexual abuse evaluations: The scientist-practitioner model. *Behavioral Sciences and the Law, 16*, 5-20.

Kuhn, J. A., Arellano, C. M. y Chavez, E. L. (1998). Correlates of sexual assault in Mexican–American and White non-Hispanic adolescent males. *Violence and Victims, 13*, 11-20.

Lameiras, M. (2002). *Abusos sexuales en la infancia: Abordaje psicológico y jurídico*. Biblioteca Nueva.

Larson, J. H., Newell, K. E., Holman, T. B. y Feinauer, I. D. (2007). The role of family environment in the dating relationships and readiness for marriage of young adult male survivors of non-familial childhood sexual abuse. *The American Journal of Family Therapy, 35*, 173-186.

Lazarus, R. S. (1993). Coping theory and research: Past, present, and future. *Psychosomatic Medicine, 55*, 234-247.

Leahy, T., Pretty, G. y Tenenbaum, G. (2004). Perpetrator methodology as a predictor of traumatic symptomatology in adult survivors of childhood sexual abuse. *Journal of Interpersonal Violence, 19*, 521-540.

Leclerc, B., Proulx, J. y Beauregard, E. (2009). Examining the modus operandi of sexual offenders against children and its practical implications. *Aggression and Violent Behavior, 14*, 5-12.

Lemieux, S. R. y Byers, E. S. (2008). The sexual well-being of women who have experienced child sexual abuse. *Psychology of Women Quarterly, 32*, 126-144.

Levitan, R. D., Rector, N. A., Sheldon, T. y Goering, P. (2003). Childhood adversities associated with major depression and/or anxiety disorders in a community sample of Ontario: Issues of co-morbidity and specificity. *Depression and Anxiety, 17*, 34-43.

López, F. (1994). *Los abusos sexuales de menores. Lo que recuerdan los adultos.* Madrid: Ministerio de Asuntos Sociales.

Luo, Y., Parish, W. L. y Laumann, E. O. (2008). A population-based study of childhood sexual contact in China: Prevalence and long-term consequences. *Child Abuse & Neglect, 32*, 721-731.

Luster, T. y Small, S. A. (1997). Sexual abuse history and problems in adolescence: exploring the effects of moderating variables. *Journal of Marriage and the Family, 59*, 131-142.

Mannarino, A. P. y Cohen, J. A. (1996). Abuse related attributions and perceptions, general attributions, and locus of control in sexually abused girls. *Journal of Interpersonal Violence, 11*, 162-180.

Mannarino, A. P. y Cohen, J. A., Smith, J. A. y Moore-Motily, S. (1991). Six- and twelve-month follow-up of sexually abused girls. *Journal of Interpersonal Violence, 6*, 494-511.

Marivate, P. y Madu, S. N. (2007). Levels of social support and coping strategies in adult survivors of child sexual abuse. *Journal of Psychology in Africa, 17*, 133-136.

McClure, F. H., Chavez, D. V., Agars, M. D., Peacock, M. J. y Matosian, A. (2008). Resilience in sexually abused women: Risk and protective factors. *Journal of Family Violence, 23*, 81–88.

McCranna, D., Lalor, K. y Katabaro, J. K. (2006). Childhood sexual abuse among university students in Tanzania. *Child Abuse & Neglect, 30*, 1343-1351.

McLean, L. M., y Gallop, R. (2003). Implications of childhood sexual abuse for adult borderline personality disorder and complex posttraumatic stress disorder. *American Journal of Psychiatry, 160*, 369-371.

McMillen, C. y Zuravin, S. (1997). Attributions of blame and responsibility for child sexual abuse and adult adjustment. *Journal of Interpersonal Violence, 12*, 30-48.

Mellon, M. W., Whiteside, S. P. y Friedrich, W. (2006). The relevance of fecal soiling as an indicator of Child Sexual Abuse: A preliminary analysis. *Developmental and Behavioral Pediatrics, 27*, 25-32.

Merrill, L. L., Thomsen, C. J., Sinclair, B. B., Gold, S. R. y Milner, J. S. (2001). Predicting the impact of child sexual abuse on women: The role of abuse severity, parental support, and coping strategies. *Journal of Consulting and Clinical Psychology, 69*, 992-1006.

Merrill, L. L., Guimond, J. M. y Thomsen, C. J. (2003). Child sexual abuse and number of sexual partners in young women: The role of abuse severity, coping style, and sexual functioning. *Journal of Consulting and Clinical Psychology, 71*, 987-996.

Moreno, B., Morante, M. E., Rodríguez, R., y Rodríguez, A. (2008). Resistencia y vulnerabilidad ante el trauma: El efecto moderador de las variables de personalidad. *Psicothema, 20*, 124-130.

Mujgan, A., Ethem, E., Oya, E., Deniz, A., Omer, U. y Ozdemir, I. (2006). Sexual abuse among female high school students in Istanbul, Turkey. *Child Abuse & Neglect, 30*, 247-255.

Myers, J. E. B., Berliner, L., Briere, J., Hendrix, C. T., Jenny, C. y Reid, T. A. (eds.) (2002). *The APSAC Handbook on Child Maltreatment*. Thousand Oaks, CA: Sage.

Najdowski, C. J. y Ullman, S. E. (2009). PTSD symptoms and self-rated recovery among adult sexual assault survivors: The effects of traumatic life events and psychosocial variables. *Psychology of Women Quarterly, 33*, 43-53.

Noll, J. G., Trickett, P. K. y Putnam, F. W. (2003). A prospective investigation of the impact of childhood sexual abuse on sexuality in adolescence and early adulthood. *Journal of Consulting and Clinical Psychology, 71*, 575-585.

Noll, J. G., Trickett, P. K., Susman, E. J. y Putnam, F. W. (2006). Sleep disturbances and childhood sexual abuse. *Journal of Pediatric Psychology, 31*, 469-480

Oaksford, K. L. y Frude, N. (2001). The prevalence and nature of child sexual abuse: Evidence from a female university sample in the UK. *Child Abuse Review, 10*, 49-59.

Oliver, B. E. (2007). Three steps to reducing child molestation by adolescents. *Child Abuse & Neglect, 31*, 683-689.

Paivio, S. C. (2001). Stability of retrospective self-reports of child abuse and neglect before and after therapy for child abuse issues. *Child Abuse & Neglect, 25*, 1053-1068.

Paolucci, E. O., Genuis, M. L. y Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *The Journal of Psychology, 135*, 17-36.

Parker, G. y Lee, C. (2007). Relationships among abuse characteristics, coping strategies, and abused women's psychological health: A path model. *Journal of Interpersonal Violence, 22*, 1184-1198.

Pazzani, L. M. (2007). The factors affecting sexual assaults committed by strangers and acquaintances. *Violence Against Women, 13*, 717-749.

Pearce, J. W. y Pezzot-Pearce, T. D. (1997). Assesment of the child. En Pearce, J. W. y Pezzot-Pearce, T. D., *Psychotherapy of abused and neglected children*. New York: The Guilford Press.

Pereda, N. (2009). Consecuencias psicológicas iniciales del abuso sexual infantil. *Papeles del Psicólogo, 30*, 135-144.

Pereda, N. y Forns, M. (2007). Prevalencia y características del abuso sexual infantil en estudiantes universitarios españoles. *Child Abuse & Neglect, 31*, 417-426.

Pereda, N., Guilera, G., Forns, M. y Gómez-Benito, J. (2009). The international epidemiology of child sexual abuse: A continuation of Finkelhor (1994). *Child Abuse & Neglect, 33*, 331-342.

Perrot, P., Morris, E., Martin, J. y Romans, S. (1998). Cognitive coping styles of women sexually abused in childhood: A qualitative study. *Child Abuse & Neglect, 22*, 1135-1149.

Peter, T. (2008). Speaking about the unspeakable. Exploring the impact of mother-daughter sexual abuse. *Violence Against Women, 14*, 1033-1053.

Plotzker, R. E., Metzger, D. S. y Holmes, W. C. (2007). Childhood Sexual and Physical Abuse histories, PTSD, depression, and HIV risk outcomes in women injection drug users: A potential mediating pathway. *The American Journal on Addictions, 16*, 431-438.

Priebe, G. y Svedin, C.G. (2008). Child sexual abuse is largely hidden from the adult society: An epidemiological study of adolescents' disclosures. *Child Abuse & Neglect, 32*, 1095-1108.

Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of American Academy of Child and Adolescence Psychiatry, 42*, 269-278.

Quas, J. A., Goodman, G. S. y Jones, D. P. H. (2003). Predictors of attributions of self-blame and internalizing behavior problems in sexually abused children. *Journal of Child Psychology and Psychiatry, 44*, 723-736.

Raghavan, C. y Kingston, S. (2006). Child sexual abuse and posttraumatic stress disorder: The role of age at first use of substances and lifetime traumatic events. *Journal of Traumatic Stress, 19*, 269-278.

Randolph, M. E. y Reddy, D. M. (2006). Sexual Abuse and sexual functioning in a chronic pelvic pain sample. *Journal of Child Sexual Abuse, 15*, 61-78.

Richmond, J. M., Elliott, A. N., Pierce, T. W., Aspelmeier, J. E. y Alexander, A. A. (2009). Polyvictimization, childhood victimization, and psychological distress in college women. *Child Maltreatment, 14*, 127-147.

Rind, B., Tromovich, P. y Bauserman, R. (1998). A meta-analytic examination of assumed properties of child sexual abuse using college samples. *Psychological Bulletin,* 124, 22-53.

Rohde, P., Ichikawa, L., Simon, G. E., Ludman, E. J., Linde, J. A., Jeffery, R.W. y Operskalski, B. H. (2008). Associations of child sexual and physical abuse with obesity and depression in middle-aged women. *Child Abuse & Neglect, 32*, 878-887.

Romano, E. y De Luca, R. V. (2001). Male sexual abuse: A review of effects, abuse characteristics, and links with later psychological functioning. *Aggression and Violent Behavior, 6*, 55-78.

Rosenthal, M. Z., Rasmussen, M. L., Palm, K. M., Batten, S. V. y Follette, V. M. (2005). Chronic avoidance helps explain the relationship between severity of childhood sexual abuse and psychological distress in adulthood. *Journal of Child Sexual Abuse, 14*, 25-41.

Roy, A. y Janal, M. (2006). Gender in suicide attempt rates and childhood sexual abuse rates: is there an interaction? *Suicide and Life-Threatening Behavior, 36,* 329-335.

Rumstein-McKean, O. y Hunsley, J. (2001). Interpersonal and family functioning of female survivors of childhood sexual abuse. *Clinical Psychology Review, 21*, 471-490.

Runtz, M. G. y Schallow, J. R. (1997). Social support and coping strategies as mediators. *Child Abuse & Neglect, 21*, 211-226.

Russell, D. E. H. (1986). *The secret trauma: Incest in the lives of girls and women*. Nueva York: Basic Books.

Sapp, M. V. y Vandeven, A. M. (2005). Update on Childhood Sexual Abuse. *Postgraduate Obstetrics & Gynecology, 25*, 1-7.

Seligman, M. E., Abramson, L. Y., Semmel, A. y von Baeyer, C. (1979). Depressive attributional style. *Journal of Abnormal Psychology, 88*, 242-247.

Shapiro, D. L. y Levendosky, A. A. (1999). Adolescent survivors of childhood sexual abuse: The mediating role of attachment style and coping in psychological and interpersonal functioning. *Child Abuse & Neglect, 23*, 1175-1191.

Shipman, K., Zeman, J., Fitzgerald, M. y Swisher, L. M. (2003). Regulating emotion in parent-child and peer relationships: A Comparison of sexually maltreated and nonmaltreated girls. *Child Maltreatment, 8*, 163-172.

Smith, D., Letourneau, E. J., Saunders, B. E., Kilpatrick, D. G., Resnick, H. S. y Best, C. (2000). Delay in disclosure of childhood rape: Results from a national survey. *Child Abuse & Neglect, 24*, 273-287.

Smith, S. G. y Cook, S. L. (2008). Disclosing sexual assault to parents. The influence of parental messages about sex. *Violence Against Women, 14*, 1326-1348.

Speizer, I. S., Goodwin, M., Whittle, L., Clyde, M. y Rogers, J. (2008). Dimensions of child sexual abuse before age 15 in three Central American countries: Honduras, El Salvador, and Guatemala. *Child Abuse & Neglect, 32*, 455-462.

Sperry, D. M. y Gilbert, B. O. (2005). Child peer sexual abuse: Preliminary data on outcomes and disclosure experiences. *Child Abuse & Neglect, 29*, 889-904.

Spaccarelli, S. (1994). Stress, appraisal, and coping in child sexual abuse: A theoretical and empirical review. *Psychological Bulletin, 116*, 1-23.

Spitalnick, J. S., Younge, S. N., Sales, J. M. y Diclemente, R. J. (2008). Sexual abuse in childhood: The abused child. En T. P. Gullota & G. M. Blau, (Eds.), *Family influences on childhood behavior and development*. Taylor & Francis Group.

Spokas, M., Wenzel, A., Wiltsey Stirman, S., Brown, G. K. y Beck, A. T. (2009). Suicide risk factors and mediators between childhood sexual abuse and suicide ideation among male and female suicide attempters. *Journal of Traumatic Stress, 00*, 1-4.

Sigfusdottir, I. D., Asgeirsdottir, B. B., Gudjonsson, G. H. y Sigurdsson, J. F. (2008). A model of sexual abuse's effects on suicidal behavior and delinquency: The role of emotions as mediating factors. *Journal of Youth Adolescence, 37*, 699-712.

Steel, J., Sanna, L., Hammond, B., Whipple, J. y Cross, H. (2004). Psychological sequelae of childhood sexual abuse: Abuse-related characteristics, coping strategies, and attributional style. *Child Abuse & Neglect, 28*, 785-801.

Stevenson, W., Maton, K. I. y Teti, D. M. (1999). Social support, relationship quality, and well-being among pregnant adolescents. *Journal of Adolescence, 22*, 109-121.

Street, A. E., Gibson, L. E. y Holohan, D. R. (2005). Impact of childhood traumatic events, trauma-related guilt, and avoidant coping strategies on PTSD symptoms in female survivors of domestic violence. *Journal of Traumatic Stress, 18*, 245-252.

Tarren-Sweeney, T. (2008). Predictors of problematic sexual behavior among children with complex maltreatment histories. *Child Maltreatment, 13*, 182-198.

Thoresen, S. y Øverlien, C. (2009). Trauma victim: Yes or no?: Why it may be difficult to answer questions regarding violence, sexual abuse, and other traumatic events. *Violence Against Women, 15*, 699-719.

Tremblay, C., Hebert, M. y Piché, C. (1999). Coping strategies and social support as mediators of consequences in child sexual abuse victims. *Child Abuse & Neglect, 23*, 929-945.

Trickett, P. K., Noll, J. G., Reiffman, A. y Putnam, F.W. (2001). Variants of intrafamilial sexual abuse experience: Implications for long term development. *Journal of Development and Psychopathology, 13*, 1001-1019.

Trickett, P. K. y Putnam, F. W. (1991). *Patterns of symptoms in prepubertal and pubertal sexually abused girls.* Paper presented at the Annual Meeting of the American Psychological Association, August, San Francisco, CA.

Tsun-yin, E. L. (1998). Sexual abuse trauma among chinese survivors. *Child Abuse & Neglect, 22*, 1013-1026.

Ullman, S. E. (2007). Relationship to perpetrator, disclosure, social reactions, and PTSD symptoms in child sexual abuse survivors. *Journal of Child Sexual Abuse, 16*, 19-36.

Ullman, S. E. y Filipas, H. H. (2005). Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors. *Child Abuse & Neglect, 29*, 767-782.

Vaddiparti, K., Bogetto, J., Callahan, C., Abdallah, A. B., Spitznagel, E. L. y Cottler, L. B. (2006). The effects of childhood trauma on sex trading in substance using women. *Archives of Sexual Behavior, 35*, 451-459.

Valle, L. A. y Silovsky, J. F. (2002). Attributions and adjustment following child sexual and physical abuse. *Child Maltreatment, 7*, 9-24.

Walsh, K., Blaustein, M., Knight, W. G., Spinazzola, J. y Van der Kolk, B. A. (2007). Resiliency factors in the relation between childhood sexual abuse and adulthood sexual assault in college-age women. *Journal of Child Sexual Abuse, 16*, 1-17.

Walsh, K., Fortier, M. A., DiLillo, D. (2010). Adult coping with childhood sexual abuse: A theoretical and empirical review. *Aggression and Violent Behavior. En prensa.*

Weaber, T. L., Chard, K. M., Mechanic, M. B. y Etzel, J. C. (2004). Self-injurious behaviors, PTSD arousal, and general health complaints within a treatment-seeking sample of sexually abused women. *Journal of Interpersonal Violence, 19*, 558-575.

Weiler, B. L. y Widom,C. S. (1996) Psychopathy and violent behaviour in abused and neglected young adults. *Criminal Behavior and Mental Health, 6*, 253-271.

Whealin, J. M. y Jackson, J. L. (2002). Childhood unwanted sexual attention and young women's present self-concept. *Journal of interpersonal violence, 17*, 854-871.

Whiffen, V. E. y Macintosh, H. B. (2005). Mediators of the link between childhood sexual abuse and emotional distress. A critical review. *Trauma, Violence & Abuse, 6*, 24-39.

Widom, C. S. (1999). Posttraumatic stress disorder in abused and neglected children grown up. *American Journal of Orthopsychiatry, 56*, 1223-1229.

Widom, C. S., Marmostein, N. R. y White, H. R. (2006). Childhood victimization and illicit drug use in middle adulthood. *Psychology of Addictive Behaviors, 20*, 394-403.

Wilson, H. W. y Widom, C. S. (2009). A prospective examination of the path from Child Abuse and Neglect to illicit drug use in middle adulthood: The potential mediating role of four risk factors. *Journal of Youth Adolescence, 38*, 340-354.

Wolfe, V. V., Gentile, C. y Wolfe, D. A. (1989). The impact of sexual abuse on children: A PTSD formulation. *Behavior Therapy, 20*, 215-228.

Wright, M. O., Crawford, E. y Sebastian, K. (2007). Positive resolution of childhood sexual abuse experiences: The role of coping, benefit-finding and meaning-making. *Journal of Family Violence, 22*, 597-608.

Yen, Ch. F., Yang, M. S., Yang, M. J., Su, Y. Ch., Wang, M. H. y Lan, Ch. M. (2008). Childhood physical and sexual abuse: Prevalence and correlates among adolescents living in rural Taiwan. *Child Abuse & Neglect, 32*, 429–438.